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12 SACRAMENTO, CALIFORNIA

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15 WEDNESDAY, JUNE 18, 1986

16 1:45 P.M.

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25 Reported by:

26 Evelyn Mizak
27 Shorthand Reporter
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APPEARANCES

MEMBERS PRESENT

SENATOR WILLIAM CRAVEN, Vice Chairman

SENATOR HENRY MELLO

SENATOR NICHOLAS PETRIS

MEMBERS ABSENT

SENATOR DAVID ROBERTI, Chairman

SENATOR JOHN DOOLITTLE

STAFF PRESENT

CLIFF BERG, Executive Officer

PAT WEBB, Committee Secretary

RICK ROLLENS, Consultant on Bill Referrals

NANCY MICHEL, Consultant on Appointments

ALSO PRESENT

GILBERT G. OLIVARRIA, Member
State Bar Board of Governors

OTIS THURMAN, Warden
California Institution for Men at Chino

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GILBERT G. OLIVARRIA, Member
State Bar Board of Governors

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P R O C E E D I N G S

--oo0oo--

VICE CHAIRMAN CRAVEN: Governor's Appointees appearing today, first is Gilbert G. Olivarria, Member, State Bar Board of Governors.

I will state before we begin that in the case of Mr. Olivarria, we will listen to Mr. Olivarria, but we will withhold vote until next week when our Chairman will be with us.

Mr. Olivarria, we ask all of the members appearing under the circumstance in which you appear today to state why they feel that they are qualified for the job to which they have been appointed.

MR. OLIVARRIA: Thank you, sir. My name is Gilberto G. Olivarria, O-l-i-v-a-r-r-i-a.

Thank you very much for the opportunity to come before the Rules Committee. I know it's required, but I still appreciate the opportunity.

I think that I can lend, based on my 17 years of experience as a law enforcement officer, six years of which are in the administrative capacity, I think that I can lend experience and training in the administration of the State Bar.

I have had considerable experience in budget matters, also in disciplinary matters, and in the total administrative process.

VICE CHAIRMAN CRAVEN: Very well.

Senator Mello.

1 SENATOR MELLO: You're looking at the two non-attorneys
2 of the Rules Committee.

3 VICE CHAIRMAN CRAVEN: That's right. So you'll get a
4 fair hearing today.

5 (Laughter.)

6 SENATOR MELLO: The thought that comes to mind is last
7 year we had a suspension of the rules paying authority of
8 attorneys who were members of the State Bar. I don't know
9 whether this will come under your purview or not as a member of
10 the Bar, but is there a need for some legislation or some changes
11 as far as the relationship between practicing attorneys in the
12 State Bar in your opinion?

13 MR. OLIVARRIA: I have to respond by telling you that
14 I've only been on the Board of Governors since September, and
15 it's taken me about three months to really understand what's
16 going on.

17 I'm not sure I understand the situation that you're
18 referring to.

19 SENATOR MELLO: I think there's some 5-10,000 backlog of
20 complaints against individual attorneys, and I think the reason
21 why there was some suspension of some legislation that would have
22 enacted another way of paying dues was because of this backlog
23 and the reprimand that is being performed by the State Bar.

24 That's why I qualified my statement by saying I'm not a
25 member of the Bar, but this does raise some concern as far as the
26 overall image and relationship that we have in California by our
27 practicing members of the Bar.
28

1 MR. OLIVARRIA: Yes, sir. There is a real concern
2 there.

3 I have been assigned to the Discipline Committee.
4 Initially it was Admissions and Discipline, but that's been
5 separated into two different committees.

6 The backlog problem is definitely there. I think
7 there's something like 6,000 cases that have accumulated over the
8 last four or five years that have not been properly investigated.
9 There are numerous moves or changes that the Board of Governors
10 have implemented since I have been on the Board that I think are
11 specifically designed to address those problems.

12 The attention that the Legislature and that the media
13 has placed on this problem has also instigated, stimulated a lot
14 of interest within the Board of Governors to correct this
15 problem.

16 I think that there are some very, very substantial,
17 significant changes that have been implemented that, along with
18 the oversight responsibility that the Legislature has taken,
19 especially with Senator Presley's two bills which are designed to
20 address these problems, I think that the movement is there.
21 Whether it moves fast enough we don't know, and we'll have to
22 look at it in probably another four or five months.

23 SENATOR MELLO: Some of the documents we have down in
24 our background show that there's some 90,000 lawyers in the
25 state; disciplinary cases take an average of 3½ years; 94 percent
26 of the complaints are dismissed; only 11 attorneys were disbarred
27 in 1984.
28

1 I think the overall backlog and slowness of really
2 performing the kind of accountability is, I think, damaging to
3 the profession as well as it leaves doubt in people's minds
4 throughout the state.

5 My reason for asking you this question, I think
6 something has to be done, whether it's the Bar itself do
7 something or the Legislature, in order to reverse this trend and
8 expeditiously handle all these complaints.

9 MR. OLIVARRIA: I totally agree with you.

10 As the Appointee of the Governor as a public member, I
11 think that my background as a law enforcement officer may have
12 played a role in the reason why I was appointed. I have already
13 had significant input in some of the changes that have taken
14 place within the Bar, especially in creating the Office of
15 Investigation and in looking for a qualified police-type
16 investigator-manager for that position.

17 The current backlog is approximately 6,000 cases. Two
18 years ago, the average time for the resolution of a complaint was
19 about 27 months; it's now down to 12-15 months, so there is some
20 movement in that case.

21 But I totally agree with you that the image that the
22 State Bar has, and the image that a lot of our attorneys have,
23 needs to be cleaned up, and that's what the job will be.

24 SENATOR MELLO: Thank you.

25 VICE CHAIRMAN CRAVEN: Mr. Olivarria, what is the State
26 Bar's policy on affirmative action for the Boards of Directors of
27 the legal services organizations?
28

1 MR. OLIVARRIA: The Legal Services Trust Fund Commission
2 has established -- the Board of Governors has established by
3 resolution a matrix that has to be very strictly adhered to.

4 One of the first appointments that I've made, or
5 recommendations I've made to the Committee on Community
6 Relations, was a Hispanic public member to the Legal Services
7 Trust Fund Commission. That was in order to fill that matrix,
8 not to mention that the person was extremely qualified, having a
9 background in accounting and government auditing services.

10 So, there is a matrix for the Legal Services Trust Fund
11 Commission that must be followed.

12 VICE CHAIRMAN CRAVEN: Well, let me give you an example.
13 The 24 members of the Board of Directors of the Western Center on
14 Law and Poverty are the only statewide legal services backup
15 center; 13 Directors are appointed by the State Bar Board of
16 Governors, and yet of the 16 attorney directors, there are no
17 Hispanic directors, and there's only one Black and only one Asian
18 director.

19 MR. OLIVARRIA: That doesn't surprise me.

20 I might add that I don't think that we've had too many
21 Hispanic members of the Board of Governors, either. My
22 understanding is that there's never been an attorney Hispanic
23 member of the Board of Governors. In fact, there's only been one
24 other before myself, and that is our public member.

25 My understanding is there are three people on that Board
26 that are Hispanic but are not attorneys.

27 VICE CHAIRMAN CRAVEN: I see.
28

1 MR. OLIVARRIA: My understanding also is that there are
2 some positions to be filled within this next coming meeting. I
3 have not looked at the list of qualified applicants. I will take
4 a look at those.

5 It is also my understanding that this December, the
6 Board of Governors will appoint 13 members, the total number that
7 it is required to appoint.

8 VICE CHAIRMAN CRAVEN: Very well.

9 Anything further?

10 Mr. Olivarria, just for your information, as you can see
11 your comments are being stenotyped and will be transcribed and
12 available to the other members of this committee to read before
13 passing a judgment by virtue of their vote at the next regularly
14 scheduled meeting. So, we'll leave you with that.

15 Thank you very much for being with us. We appreciate it
16 very much.

17 Next is Mr. Otis Thurman, Warden, California Institution
18 for Men at Chino.

19 Mr. Thurman you heard the comments I made to Mr.
20 Olivarria as to why you feel you're qualified for this job.

21 MR. THURMAN: Yes, thank you, sir.

22 VICE CHAIRMAN CRAVEN: You're welcome.

23 MR. THURMAN: I'd like to take the opportunity to
24 express my gratitude for the opportunity. Also, to tell you a
25 little bit about my career and qualifications.

26 VICE CHAIRMAN CRAVEN: Please do.

27
28

1 MR. THURMAN: It spans 24 years in the correctional
2 system. I began as a Correctional Officer at D.V.I. Tracy; went
3 to the Youth Authority; promoted up through the ranks there; came
4 back to the Department of Corrections; have been in every
5 classification from lieutenant, program administrator,
6 correctional administrator, deputy superintendent, and now
7 currently superintendent. Spans 24 years, approximately eight
8 different facilities.

9 Also, I was the administrator for the Correctional
10 Officers' Training academy for two years. I have a Bachelor of
11 Arts degree and some graduate work.

12 So, I think I have a lot of experience and
13 qualifications in terms of doing the job as the Warden of the
14 California Institution for Men.

15 VICE CHAIRMAN CRAVEN: Very well.

16 Senator Mello.

17 SENATOR MELLO: We're becoming somewhat experts of our
18 prison system by having these different prisons come in to
19 receive confirmation.

20 Looking over some of the background, I know very little
21 about Chino. I have Soledad Prison in my district, and you have
22 a similar situation. We had a little over 200 percent
23 overcrowding; you're running above that.

24 MR. THURMAN: Yes, sir.

25 SENATOR MELLO: This is an intolerable situation from my
26 perspective, probably yours, too.

27

28

1 What are some of the things we should be doing to
2 eliminate or prevent the problems that we're having in our
3 institutions?

4 MR. THURMAN: Which problems are you speaking of,
5 Senator?

6 SENATOR MELLO: Well, the overcrowding; there's a lot of
7 violence that occurs, harassment.

8 Speaking from what I see in my own area, we're
9 converting a lot of space that was used for education, for the
10 arts program, for crafts, vocational training, over to, you know,
11 bed space for inmates. I think we're getting more to a
12 warehousing situation when we have this kind of overcrowding, and
13 we really can't provide meaningful programs of true
14 rehabilitation. That's a concern I continue to have.

15 I'd just like to hear your views as a warden of one of
16 these institutions.

17 MR. THURMAN: Those are my concerns, too, to insure that
18 the inmates do have proper programming, educational/vocational
19 training, et cetera.

20 Currently, as you know, we're netting 300 additional
21 inmates per week in our system. The overcrowding issue is a
22 reality until we get some new beds on line.

23 What we're trying to do at this point in time is still
24 provide some kind of vocational training, some kind of academic
25 training, and other related programs. The opportunities are
26 limited because of the overcrowding issue, but it isn't
27 forgotten.
28

1 SENATOR MELLO: In your opinion, what programs are
2 working and do you think have to be protected and expanded as far
3 as lending itself toward rehabilitation?

4 MR. THURMAN: Well, I think, you know, in any prison
5 situation I think the academic program. That's probably one of
6 the keys to any kind of rehabilitation, the ability for a person
7 to read and write, to get a job, you know, to present himself in
8 an orderly fashion while he tries to get a job. So, I think the
9 academic has to be maintained.

10 Secondarily, the vocational programs, which train people
11 for occupations and vocations when they're released.

12 So, I think those two items we're probably going to
13 never give up. Some of the other kinds of things we'd like to do
14 and continue is, you know, the secondary kind of education, other
15 kinds of -- they've got some computer programs going. So, there
16 are a lot of things that aren't forgotten, still going on, but on
17 a smaller scale because of the overcrowding issue at this point
18 in time.

19 SENATOR MELLO: As far as education now, the basic one
20 leads to a G.E.D. diploma?

21 MR. THURMAN: Yes, G.E.D. and actual high school --
22 graduation from high school. They can also get a high school
23 degree.

24 SENATOR MELLO: Where can a person being released from
25 our institutions really go out and get a job that would sustain
26 that person with a G.E.D. diploma?

27
28

1 MR. THURMAN: That's a difficult situation because even
2 people who haven't been incarcerated have difficulty going out
3 and getting a job with a G.E.D. Compounded with the, you know,
4 with the history of criminality makes it worse.

5 But again, the motivation of the person, you know, with
6 the G.E.D. or with the high school education, is contingent on
7 the person going out and getting a job, and society given him an
8 opportunity to get a job.

9 SENATOR MELLO: You used some terms: We're not going to
10 give up hope or we're not going to let some of these programs be
11 forgotten.

12 I was trying to ascertain your perspective. That
13 doesn't come across as being aggressive, to try to improve and
14 expand them.

15 Mr. McCarthy is here and his staff. Are you going to
16 him and saying: Hey, we can't afford to lose these programs; we
17 have to do more of it? Or are you just allowing him to take away
18 from programs as the need arises?

19 MR. THURMAN: Well, the reality --

20 SENATOR MELLO: They're not looking at you right now.

21 (Laughter.)

22 MR. THURMAN: The reality, you know, with the population
23 increasing that we have no control over, we still have to place
24 the inmates someplace. So, you know, it's not the most ideal
25 situation, but we're having to cut back on some programs based on
26 space needs.

1 But we're not eliminating programs, academic/vocational
2 programs. They're still going on.

3 I'm saying hopefully, when the beds come on line, the
4 kinds of increased activity in both of those areas and other
5 areas will be better, but you need space in order to program.

6 SENATOR MELLO: You say when the beds come on line, if
7 we're admitting 300 people a week, which is a figure I've been
8 hearing for the last five years, that translates into 15,000 a
9 year, and of course some are leaving the institution, so the net
10 gain is, what, five or six constitutions per year.

11 We're not building that many beds. We're not providing
12 that much extra space. I don't see how we're ever going to catch
13 up with overcrowding, from my perspective.

14 I think there are several things, and I'm not into
15 criminology, other than just a lay person who's very frustrated
16 about it. I think we have to do more in the front end, in
17 education prevention, prevent crime from happening, and that's
18 probably a dream that people have that's not working out as we
19 hoped it would. Once they foul up and get into the system, then
20 I think we have to make sure that we provide the kind of humane
21 care, but also try to cut down on recidivism by really
22 rehabilitating a person, giving him self-esteem and confidence so
23 they can go out into the world and compete and become
24 self-sufficient.

25 Right now, the numbers are just staggering. I spoke to
26 a group of educators last night, and they asked me: How can we
27 get enough money in California to help support education? We're
28 37th in the country.

1 We're just not putting up the money, but we seem to find
2 the money to build more jails and more prisons. I'd rather see
3 more money going in for education.

4 I support the money to build more prisons, but I think
5 that's an existing problem. But I think for a longer term, we
6 should be building more and trying to keep people out of our
7 institutions if we possibly can. Some who are habitual type
8 criminals, I don't think anything can keep them from doing the
9 ugly things they do, but those that sort of fall into crime for
10 other reasons -- lack of employment, lack of education,
11 discrimination, whatever the case might be, a lot of them are
12 drug related -- I think we should by all means do what we can to
13 turn those things around.

14 Let me ask you one final question. Art in Corrections,
15 is that program working or not?

16 MR. THURMAN: Yes, it is.

17 SENATOR MELLO: Did they tell you to say that or not?

18 (Laughter.)

19 MR. THURMAN: No, they didn't have to.

20 SENATOR MELLO: I was trying to mask that question
21 because the Department knows how interested I am in Art in
22 Corrections.

23 I just have the idea that every person that comes up
24 here for confirmation, they say: Now, look, Senator Mello's
25 going to ask about Art in Corrections, and be sure you tell him
26 it's a heck of a good program.

27

28

1 MR. THURMAN: I happen to have some facts and figures in
2 my pocket.

3 (Laughter.)

4 SENATOR MELLO: All right.

5 MR. THURMAN: On the Arts in Corrections program.

6 At C.I.M., for instance, we have three phases. Actually
7 we have a \$6,000 budget for Arts in Corrections at C.I.M. We
8 have a phase where we do -- people come in and do workshops,
9 theatrical kinds of things, artistic kinds of things. I think we
10 have three people involved in that program.

11 We have a crew of seven whose primary responsibility is
12 beautification of the institution, and they've done some really
13 beautiful murals, some other kind of art work throughout the
14 institution, and it really improves the looks of the institution.

15 It also provides some incentive for some of the inmates
16 to learn and gain some new skills, and hopefully it will help
17 them when they're released.

18 In terms of the Arts in Corrections program, some more
19 money in the budget would help because I think we could do more
20 things.

21 SENATOR MELLO: Say that again. I don't think they
22 heard you.

23 MR. THURMAN: \$6,000 isn't a lot of money for the
24 program for an institution that size.

25 SENATOR MELLO: How much is that again?

26 MR. THURMAN: \$6,000.

27 SENATOR MELLO: For the whole institution of Chino?
28

1 MR. THURMAN: Yes.

2 SENATOR MELLO: We've got in the budget this year, I
3 think it's a million and two, for the Arts in Corrections. It's
4 over a million dollars right now.

5 But with about 12 institutions, I thought that we were
6 providing about \$100,000 for each one. If you're only getting
7 6,000 I think to sit down and talk to some of the people.

8 MR. MCCARTHY: Other institutions get much more, I
9 assure you.

10 SENATOR MELLO: Thank you, I wanted to ask that.

11 From our perspective, that program has really been cost
12 effective. It's done more to cut back on recidivism and give
13 people some really hope of making it on the outside.

14 And the Department has responded, I think, in a very
15 positive way. As you say, I'd like to see more money spent there
16 because I think we can use it. We can use it to, as you pointed
17 out, if you're only getting \$6,000, I think you could do a lot
18 better job with a lot more, just so they don't take that space
19 away from you and try to get more if you can.

20 Thank you very much, Mr. Thurman. I think you've
21 answered my questions very appropriately.

22 MR. THURMAN: Thank you.

23 VICE CHAIRMAN CRAVEN: Warden, do you manufacture at
24 Chino?

25 MR. THURMAN: What do --

26 VICE CHAIRMAN CRAVEN: Do you manufacture items at
27 Chino? Do you build furniture? What do you do?
28

1 MR. THURMAN: Yes, we have a prison industries program
2 at Chino in which we manufacture furniture of all kinds. We have
3 a dairy; we have a clothing operation where we make
4 handkerchiefs, underwear, all kinds of items for other
5 institutions. We have a number of those kind of programs at
6 Chino currently where we manufacture things for the institutions
7 and other state-related agencies.

8 VICE CHAIRMAN CRAVEN: Since you're located in Chino, I
9 presume that you have come to meet Senator Ayala?

10 MR. THURMAN: Yes, yes, I have.

11 VICE CHAIRMAN CRAVEN: Do you maintain a rapport with
12 Senator Ayala?

13 MR. THURMAN: I think we have a good rapport. The last
14 year I've been there, I've met a couple of his aides and have
15 responded to any issues that he's had, and I think we have a good
16 relationship.

17 VICE CHAIRMAN CRAVEN: Well, since he represents that
18 area in particular, that's his home, he has great interests in
19 your institution and the operation of it. We've heard him on the
20 Floor talking about it occasionally, so I just wondered whether
21 you really do know him and find out what a really fine person he
22 is.

23 MR. THURMAN: Yes.

24 VICE CHAIRMAN CRAVEN: Do you have anything further,
25 Henry?

26 SENATOR MELLO: No.
27
28

1 What we should do is just hold it open until another
2 member gets here.

3 VICE CHAIRMAN CRAVEN: I was just going to ask if that
4 would be agreeable to you.

5 We do expect Senator Petris, who is detained on
6 legislative business. But when he gets back, I think we'll take
7 it to a vote.

8 SENATOR MELLO: Mr. Chairman, might I ask that we keep
9 it open, and if perhaps Mr. Thurman wouldn't mind just waiting,
10 some of the other senators may have some questions. We could
11 just suspend the hearing on his part and then reopen it at a
12 later point.

13 VICE CHAIRMAN CRAVEN: All right. We'll do it that way.

14 MR. THURMAN: Thank you.

15 VICE CHAIRMAN CRAVEN: I'm presuming that there's no one
16 in objection. I've heard no rumbles along those lines.

17 I'm willing to stipulate that about nine-tenths of the
18 people sitting out there are in favor. So, that being the case,
19 we'll just dismiss with that portion.

20 (Thereupon the Committee took up
21 legislative matters and then went
22 into Executive Session.)

23 VICE CHAIRMAN CRAVEN: Senator Petris, do you have any
24 questions for Mr. Thurman? We'll reopen the hearing.

25 SENATOR PETRIS: No.

26 VICE CHAIRMAN CRAVEN: We don't have a motion.
27
28

1 SENATOR MELLO: I would move the confirmation of Mr.
2 Thurman be recommended to the Floor.

3 VICE CHAIRMAN CRAVEN: Very well, call the roll.

4 SECRETARY WEBB: Senator Doolittle. Senator Mello.

5 SENATOR MELLO: Aye.

6 SECRETARY WEBB: Senator Petris.

7 SENATOR PETRIS: Aye.

8 SECRETARY WEBB: Senator Craven.

9 VICE CHAIRMAN CRAVEN: Aye.

10 SECRETARY WEBB: Senator Roberti.

11 VICE CHAIRMAN CRAVEN: Three to zero; you're recommended
12 to the Floor. Thank you very much, Mr. Thurman.

13 (Thereupon this portion of the
14 Senate Rules Committee hearing was
15 terminated at approximately 2:25 P.M.)

16 --oo0oo--
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CERTIFICATE OF SHORTHAND REPORTER


I, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Senate Rules Committee hearing was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this

23rd day of June, 1986.


EVELYN MIZAK
Shorthand Reporter

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16 WEDNESDAY, JUNE 25, 1986

17 2:05 P.M.

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Proceedings

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Governor's Appointees:

For Vote Only:

GILBERT G. OLIVARRIA, Member
State Bar Board of Governors

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GEORGE MEESE, Member
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P R O C E E D I N G S

--oo0oo--

CHAIRMAN ROBERTI: Governor's Appointees for vote only. The hearing did take place last week at this time, and that is Mr. Gilbert G. Olivarria, Member of the State Bar Board of Governors.

SENATOR MELLO: Move confirmation.

CHAIRMAN ROBERTI: Senator Mello moves confirmation of Mr. Olivarria's appointment.

Is there any discussion or debate?

Secretary will call the roll.

SECRETARY WEBB: Senator Doolittle. Senator Mello.

SENATOR MELLO: Aye.

SECRETARY WEBB: Senator Petris. Senator Craven.

SENATOR CRAVEN: Aye.

SECRETARY WEBB: Senator Roberti.

CHAIRMAN ROBERTI: Aye.

SENATOR MELLO: Call the roll one more time.

CHAIRMAN ROBERTI: One more time.

SENATOR PETRIS: Aye.

CHAIRMAN ROBERTI: Vote is four to zero; the confirmation is recommended to the Floor.

Governor's Appointees appearing today, George Meese, Member of the Unemployment Insurance Appeals Board.

Mr. Meese, we'll ask you what we ask all the Governor's Appointees: Why you feel you're qualified to assume this position.

1 MR. MEESE: Thank you, Mr. Chairman. I have a brief
2 opening statement, if I may.

3 CHAIRMAN ROBERTI: Yes, please.

4 MR. MEESE: I come to the Board. I've worked for 25
5 years now in Alameda County in the municipal court system there.
6 My last eight years was the Court Administrator for the
7 Livermore-Pleasanton Municipal Court.

8 I was appointed Director of the Department of Motor
9 Vehicles in March of 1983 and served there until January of this
10 year, at which time I was appointed to the Unemployment Insurance
11 Appeals Board and have served there.

12 I see my duties as a public member of the Board to be to
13 follow the law as set forth by the Legislature, to do that
14 fairly, and to do that compassionately. I think in the six
15 months that I've been there, the almost six months that I've been
16 there, that I've done that, and if allowed to continue in that
17 capacity I would follow those same guidelines.

18 CHAIRMAN ROBERTI: Thank you very much, Mr. Meese.

19 Are there any questions of Mr. Meese?

20 SENATOR CRAVEN: Move Mr. Meese's confirmation.

21 CHAIRMAN ROBERTI: Senator Craven moves George Meese's
22 confirmation be recommended to the Floor.

23 Any opposition in the audience?

24 Seeing none, Secretary will call the roll.

25 SECRETARY WEBB: Senator Doolittle.

26 SENATOR DOOLITTLE: Aye.

27 SECRETARY WEBB: Senator Mello.

28

1 SENATOR MELLO: Aye.

2 SECRETARY WEBB: Senator Petris.

3 SENATOR PETRIS: Aye.

4 SECRETARY WEBB: Senator Craven.

5 SENATOR CRAVEN: Aye.

6 SECRETARY WEBB: Senator Roberti.

7 CHAIRMAN ROBERTI: Aye.

8 The vote is five to nothing; confirmation is recommended
9 to the Floor.

10 MR. MEESE: Thank you very much, gentlemen.

11 (Thereupon this portion of
12 the Senate Rules Committee
13 hearing was terminated at
14 approximately 2:45 P.M.)

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1 CERTIFICATE OF SHORTHAND REPORTER

2

3 I, EVELYN MIZAK, a Shorthand Reporter of the State of

4 California, do hereby certify:

5 That I am a disinterested person herein; that the

6 foregoing Senate Rules Committee hearing was reported in

7 shorthand by me, Evelyn Mizak, and thereafter transcribed into

8 typewriting.

9 I further certify that I am not of counsel or attorney

10 for any of the parties to said hearing, nor in any way

11 interested in the outcome of said hearing.

12 IN WITNESS WHEREOF, I have hereunto set my hand this

13 25th day of June, 1986.

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EVELYN MIZAK
Shorthand Reporter

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SENATE RULES COMMITTEE
STATE OF CALIFORNIA

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27 Shorthand Reporter
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APPEARANCES

MEMBERS PRESENT

SENATOR DAVID ROBERTI, Chairman

SENATOR WILLIAM CRAVEN, Vice Chairman

SENATOR HENRY MELLO

SENATOR NICHOLAS PETRIS

MEMBERS ABSENT

SENATOR JOHN DOOLITTLE

STAFF PRESENT

CLIFF BERG, Executive Officer

PAT WEBB, Committee Secretary

RICK ROLLENS, Consultant on Bill Referrals

NANCY MICHEL, Consultant on Appointments

ALSO PRESENT

SENATOR HERSCHEL ROSENTHAL

STANLEY HULETT, Member
Public Utilities Commission and
Mmeber, California Transportation Commission

JANICE MONDAVI, Member
California Regional Water Quality Control Board
San Francisco Bay Region

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For Vote Only:

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Regents of the University of California

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Public Utilities Commission and
Member, California Transportation Commission

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Certificate of Reporter

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P R O C E E D I N G S

--oo0oo--

VICE CHAIRMAN CRAVEN: Governor's Appointee for vote only, in the case of Tirso Del Junco, M.D., Member, Regents of the University of California.

Are the Members of the Committee prepared to vote on this item?

SENATOR PETRIS: Move.

VICE CHAIRMAN CRAVEN: There being no further discussion, call the roll.

SECRETARY WEBB: Senator Doolittle. Senator Mello.

SENATOR MELLO: Aye.

SECRETARY WEBB: Senator Petris.

SENATOR PETRIS: Aye.

SECRETARY WEBB: Senator Craven.

VICE CHAIRMAN CRAVEN: Aye.

SECRETARY WEBB: Senator Roberti.

Three to zero.

VICE CHAIRMAN CRAVEN: Very well, thank you.

(Thereupon legislative matters
were discussed)

VICE CHAIRMAN CRAVEN: Would the Members care to begin to hear those appearing today? Very well, no objection, Senator Roberti should be here very shortly.

Let's go to Item 4, Governor's Appointees appearing today, beginning with Stanley Hulett, Member, Public Utilities Commission.

1 Mr. Hulett, if you'll come up and seat yourself at the
2 table, and we will tell you what our President Pro Tem tells all
3 the Appointees, and that is: Tell us why you feel you are
4 qualified for this appointment.

5 MR. HULETT: Thank you, Mr. Chairman, Members of the
6 Committee.

7 I appreciate the opportunity to appear before you today.

8 I have spent most of my working life involved in public
9 policy development, and I think that this position will provide
10 an unique opportunity to bring that public policy development
11 together in an area dealing with the 27 million people of this
12 state in a very direct way.

13 Our Commission, as you know, involves itself in the
14 everyday lives of virtually everybody, and I look forward to the
15 opportunity with my background in public policy and particularly
16 in energy in having the opportunity to bring this together in a
17 way to create a fair and balanced approach towards the regulation
18 of this State's utilities.

19 VICE CHAIRMAN CRAVEN: Very well.

20 Mr. Hulett, on behalf of the Members of the Committee
21 and myself, could you give us a little more in depth as to the
22 public policy in the energy field in which you have engaged?

23 MR. HULETT: Yes, sir. I'd be happy to.

24 During the late 1960s, I was on the staff of a Member of
25 Congress from California, Don Clauson, during which time we were
26 heavily involved in several water issues, most of them involving
27 energy in the north coast of California.
28

1 I then spent several years with the National Parks
2 Service and was involved in the efforts there to try to balance
3 the wise use of the resources along with their proper use for
4 energy.

5 I returned to the Department of Interior in 1981; served
6 there for three and a half years, involved very heavily in the
7 development of the energy projects of the Bureau of Reclamation
8 of the Department. I then served as a Special Assistant to the
9 Secretary of Energy and had the major responsibility to negotiate
10 an agreement for a new electrical intertie between the Pacific
11 Northwest and California.

12 VICE CHAIRMAN CRAVEN: Very well.

13 Senator Petris, do you have any questions?

14 SENATOR PETRIS: Yes, Mr. Chairman, briefly I hope.

15 There's been a recent trend among public utilities to
16 expand and diversify into fields that are totally foreign to
17 their operations. I understand PG&E is taking a look at Nutra-
18 Sweet, for example. I don't know what that connection is, but I
19 guess some appropriate comment might be made on it. Southern Cal
20 Edison has already acquired, their parent company acquired or
21 agreed to acquire Thrifty Corporation, which is a drug and
22 discount chain, for stock valued at close to a billion dollars,
23 885 million.

24 Do you see that impacting on the role of the Commission
25 and where you'll be sitting in terms of examining the books of
26 the company on the fair rate of return, and notions of that kind?
27 Do you see an opportunity there for juggling like the railroads
28

1 used to do and shift all the costs over to the passenger cars in
2 order to accommodate the freight and higher revenue part of their
3 business?

4 To me it seems a little bit spooky. Could you comment
5 on that, please.

6 MR. HULETT: Yeah, it is a trend that I think we have to
7 watch very carefully, Senator.

8 I understand that PG&E has decided not to acquire
9 NutraSweet, which I think was a good decision on their part. I
10 was concerned and mentioned to them the potentiality with
11 liability suits being as they were, the potential that the
12 utilities side of the business could be hurt if, for instance,
13 some determination were made later that NutraSweet was a
14 carcinogenic or something else.

15 I think we have to look at each one of these things
16 separately. The Southern California Gas Company acquisition of
17 Thrifty through Pacific Lighting Corporation, their parent, was
18 -- was interesting, and we have asked the company to provide us
19 with some information as to what they see as any potential impact
20 on the utilities side of the business.

21 Our role, as I see it, is to fully protect the rate
22 payer and to make sure that the utility customer or that rate
23 payer is not hurt, and he does not get negative treatment as a
24 result of the funds that are expended by the parent company to
25 acquire another facility, another company.

26 SENATOR PETRIS: How is that policy going to be
27 expressed? Does the law give the Commission the authority now to
28 do something?

1 MR. HULETT: The law now gives the Commission the
2 responsibility to review the activities of a parent company, but
3 there really is no -- nothing in law, Senator, that says that we
4 can tell them: No, they cannot acquire. All we can do is -- is
5 recommend in terms of what we see as the impact on the rate
6 payer.

7 SENATOR PETRIS: There's a bill pending that would give
8 the Commission more power to look at the books. Are you in favor
9 of that idea?

10 MR. HULETT: I think it would be good for us to have
11 that opportunity because we do have a responsibility to the rate
12 payer, and I do think we ought to make sure that there is no
13 negative impact.

14 SENATOR PETRIS: What are the limitations now? Aren't
15 you able to go into that for rate making purposes?

16 MR. HULETT: I don't believe, and I would have to
17 respond further for the record --

18 SENATOR PETRIS: Apparently the answer is no, because
19 there's legislation pending.

20 MR. HULETT: Right.

21 SENATOR PETRIS: Maybe there's some doubt about it.

22 MR. HULETT: We really don't have a lot of ability to
23 look at the parent companies.

24 SENATOR PETRIS: Now, on the notion of rate setting and
25 rate of return, can you explain what your approach is to that?
26 What is your philosophy on the rate of return to which the
27 company is entitled? What should it be and so forth?
28

1 MR. HULETT: Well, I think we have to first of all look
2 at each one of the companies separately. They're all very
3 different. We have one all electric utility; we have one all gas
4 utility; and we have two major utilities that are both gas and
5 electric. They all vary and they're all different. They all
6 have a different capital structure.

7 I think we have to look at it in terms of what is a
8 reasonable rate of return that will attract the investment in the
9 utility that will allow the utility to continue its capital
10 program, that will allow the utility to have a high enough credit
11 rating on Wall Street that their rate of financing is low enough
12 that that doesn't hurt the rate payer because if, say, PG&E's
13 rate goes from Double A to Single A, it could mean a quarter
14 percent difference in the interest rate they would have to pay on
15 bonds. And eventually that cost will go to the rate payer.

16 So, I think we have to -- we have to balance that rate
17 of return to protect that side of the capital structure with
18 making sure that we are not allowing the company an
19 extraordinarily high rate, beyond the rates that similar
20 companies around the country are allowed, to the detriment of the
21 rate payer.

22 It's a very difficult balancing act, and I can't tell
23 you that today that 13½ percent or 14 percent, or whatever
24 number, may be correct because I simply don't know the answer to
25 that question.

26 SENATOR PETRIS: Aren't our rate payers now pretty close
27 to the top in rates nationally? We used to be way down.
28

1 MR. HULETT: They were down for a long time. The last
2 numbers I saw within the last couple of weeks indicated that San
3 Diego was now again the highest in the nation. My recollection
4 was that PG&E and Edison were both in the top ten nationally.

5 SENATOR PETRIS: How about common equity and return on
6 that?

7 MR. HULETT: Again I think we have -- we have to look at
8 the --

9 SENATOR PETRIS: No magic number?

10 MR. HULETT: I don't think we can set a magic -- it
11 would be a lot easier, frankly, if we could sit down and say:
12 Okay, here's the number today, and this is going to be the number
13 for this year, and all of you are going to have that number.

14 There is a -- between our public staff division now and
15 the utilities an effort to try to reach a settlement which would
16 be recommended to the Commission. I understand that there has
17 been agreement reached with at least two of these utilities on a
18 number that they are willing to accept and which our public staff
19 division feels is appropriate for the balance of this year for
20 two of them, and for the balance of this year and all of next
21 year for another.

22 I'm trying to remember the exact numbers. It seems to
23 me it was 14.6 for the balance of this year, and 13.9 was the --
24 at least those were the numbers that were provided by Sylvia
25 Siegel from TURN who came to see me about it yesterday.

26 SENATOR PETRIS: You know her?

27

28

1 MR. HULETT: Yes, I do. Sylvia is in my office quite
2 often.

3 SENATOR PETRIS: Well, there's several other areas, but
4 we have a long agenda. Let me just cover one more.

5 Telephones. Everybody in the land is confused. I think
6 the phone companies are confused.

7 That sharpens the role, or at least demands, on the PUC
8 to try to do something to ease what we see, according to the
9 reading I've done and people I've talked to, inevitable great big
10 jump in user rates of telephone users because of all these
11 changes.

12 What do you see the PUC doing, or what would you like
13 them to do, that might help ease the plight of the consumer in
14 this very confusing scramble for competition under the new
15 system?

16 MR. HULETT: Well first of all, you have -- you have set
17 the tone for it by saying it is very confusing, because it is
18 extremely confusing. In the short time I've been on the
19 Commission, it's been the one area that I've had the greatest
20 difficulty trying to understand.

21 We are entering an area where we have had a monopoly for
22 -- from time immemorial practically, and now it's almost total
23 competition, and trying to find a way to protect the consumer,
24 which has got to be the role of the Public Utilities Commission.
25 And what we have to do is, we have to look at that portion of it
26 that in fact we regulate, which is Pacific Bell generally. We
27 have 17 other telephone companies in California that we control,
28 but obviously the largest of that is Pacific Bell.

1 So, we have to look at Pacific Bell, and we have to make
2 sure that Pacific Bell is not earning more than it should be
3 earning, and it should be providing to the consumer a level of
4 service that equates with what that consumer is paying.

5 That's very difficult to do, because we've got all of
6 these various schemes now, and I don't mean that in a pejorative
7 sense, but all of these ideas on: how rates are established;
8 what areas are encompassed by what rates; where the alternative
9 companies are allowed to participate in, for instance, the major
10 telephone market between San Francisco and Los Angeles; and how
11 does Sprint, MCI, and all of those others, how do they
12 participate; how does AT&T participate.

13 SENATOR PETRIS: Can we look to you as a Member of the
14 Commission to help keep the rates within a reasonable level for
15 the average telephone user?

16 MR. HULETT: I certainly hope so, because every time I
17 look at my telephone bill, I want to make sure that my telephone
18 bill is held within -- within proper bounds.

19 SENATOR PETRIS: What's happening to pay phones? It's
20 very hard to find a pay phone anymore. They're not in the gas
21 stations anymore, and you go to a supermarket and they have three
22 in a great big shopping center, two of which usually aren't
23 working, and yet I hear Pacific Bell advertising their pay phones
24 all the time as if we each have a pay phone in our kitchens.

25 Something wrong's going on there.

26 MR. HULETT: Well, one of the things that came as a
27 result of Judge Greene's decision on breaking up Ma Bell has been
28

1 an effort on the part of the -- of the various operating
2 companies to sell their pay phones. Pacific Bell was the first
3 one that came forward with a proposal to do that. I understand
4 General Telephone and Continental are the other two large ones in
5 California and are proposing to do the same.

6 So, you as an individual could buy the pay phone at the
7 ABC Store down at the corner, and you would be the operator of
8 that system. You would collect the money for that, and you would
9 pay -- for that, you would pay the company a certain access
10 charge.

11 I'm not sure how that's working, and I'm not yet
12 comfortable with it. I'm not sure that that's exactly what was
13 meant by free competition, because there are emergency services
14 that we look to for the telephone.

15 SENATOR PETRIS: That's right. Is the Commission
16 looking into that?

17 MR. HULETT: We are.

18 SENATOR PETRIS: You have jurisdiction; don't you?

19 MR. HULETT: Yes, we do.

20 SENATOR PETRIS: Now, it just strikes me as odd. It's
21 the same feeling I had with the oil problem. We had these
22 wonderful lectures on letting the market determine everything, so
23 we come to an oil crisis. Then we get through the crisis, and
24 the price of oil in the Middle East goes down. And then I read
25 this article in the Wall Street Journal explaining to us why the
26 prices here are going up while demand has dropped enormously.
27 And there's this very complicated explanation which at the end
28

1 didn't tell me a darn thing. It just kind of pulled the wool
2 over my eyes.

3 Now we have this wonderful thing about competition in
4 the telephone business, and the rates keep going up; same thing.
5 I find that hard to understand or to justify in the light of the
6 god that we worship all the time, which is the market place.

7 MR. HULETT: It's very difficult because we've moved 180
8 degrees away from where we have been with our utilities services
9 for years, and it is very difficult. It's hard for us to
10 understand; it's hard for us to explain to other people, Senator,
11 why, when they read in the paper that oil is \$10 a barrel, that
12 you don't see a commensurate reduction in the price of
13 electricity.

14 SENATOR PETRIS: Well, good luck. Thank you.

15 MR. HULETT: Thank you very much, Senator.

16 VICE CHAIRMAN CRAVEN: Mr. Chairman, we had Mr. Hulett
17 come up, obviously, in your absence, and I neglected to mention
18 to my colleagues that he is not only being considered for
19 appointment to the Public Utilities Commission, but also as a
20 Member of the California Transportation Commission. Kind of
21 double jeopardy there.

22 So, if anyone has any comment that might fall into that
23 venue, the time would be appropriate, I suppose, to ask.

24 SENATOR PETRIS: Yes, I have a question on that.

25 VICE CHAIRMAN CRAVEN: I kind of thought so.

26 SENATOR PETRIS: First of all, I want to know if that's
27 legal.
28

1 VICE CHAIRMAN CRAVEN: It's the first time I've
2 experienced it.

3 SENATOR PETRIS: To hold two state offices?

4 MR. HULETT: By law, it's my understanding -- I have not
5 read the law, but I am told by law the Transportation Commission
6 is required to have one Member of the Public Utilities Commission
7 as a Member of the Transportation Commission.

8 VICE CHAIRMAN CRAVEN: That's the answer, Senator.

9 MR. HULETT: Former Assemblyman Bagley filled those two
10 places.

11 SENATOR PETRIS: It's not an entirely irrelevant
12 question. When I first came up here a hundred years ago, I was
13 compelled to resign my office as Notary Public because I couldn't
14 hold two state offices.

15 Now, if I can't even be a Notary Public, how come you
16 can be a Transportation Commissioner?

17 (Laughter.)

18 MR. HULETT: I guess because the Legislature said I
19 could.

20 VICE CHAIRMAN CRAVEN: Obviously the Commission is not
21 as consequential as a Notary Public.

22 (Laughter.)

23 VICE CHAIRMAN CRAVEN: It speaks for itself.

24 MR. HULETT: I'll try to keep that in mind as we meet.

25 VICE CHAIRMAN CRAVEN: Don't let that get back to the
26 Commissioners.

27 Henry, Do you have anything?
28

1 SENATOR MELLO: Yes, I have a couple of questions.

2 He's been very kind to agree to meet with me based on
3 some correspondence I wrote to the Commission a few weeks ago.
4 It came out of several complaints. It's an ongoing increasing
5 complaint from rate payers. It used to be from more domestics,
6 but now it's domestic and industrial and food processors and
7 everything.

8 Two weeks ago, we had a bill by the Speaker that would
9 set up a new system for allowing more access by consumers into
10 the rate making process, and the Public Utility Commission
11 opposed that very violently here before us, even though it still
12 went out.

13 Are we going to turn this around somehow so the
14 Commission actually opens up the rate setting, and not so
15 complicated, so the small rate payers can be there, or is it
16 going to remain complicated so PG&E and others come up with a
17 forklift truck full of applications, and the thing is so complex,
18 and it happens every month or so, and who can compete with that
19 kind of situation?

20 I'd like to hear your comment, if you think it'll change
21 or not?

22 MR. HULETT: Senator, I hope it does change. I think
23 the one thing that has struck me in the 60 days that I have
24 served on the Commission is the complexity of the issues that
25 come before us.

26 I'm not altogether satisfied that those issues need to
27 be nearly as complex as they are. My conversations with your
28

1 constituent -- and we've spent several hours going over all of
2 his billings for the last three or four years to try to find out
3 why, as I mentioned earlier, in a period of falling oil prices,
4 falling natural gas prices, that you don't see the same
5 commensurate reduction in the electric rates.

6 While I think the answer that we may go back to him with
7 is probably correct, I'm not sure that it fully explains the
8 situation. I think we can simplify the process.

9 I think that President Vial's opposition to Speaker
10 Brown's bill was not related so much to trying to hold consumers
11 out of the process, Senator, but is to try to allow us the
12 flexibility to look at the broader issues while at the same time
13 making sure that we do look at all of this minutia in order to
14 protect the rate payer, to make sure that the things that are in
15 the filings are correct and are representative of the business
16 practices of those utilities.

17 SENATOR MELLO: I think you as a Commissioner are going
18 to have to do something about the staff, or if this is the
19 attitude of the Commission, my letter to the Commission
20 specifically asked the question: Back in the '70s, when oil
21 prices had gone up, we got increases every two weeks or every
22 month. And they all said: Due to increasing oil prices, our
23 rate is now such-and-such.

24 So I asked: How come now that oil has dropped from \$45
25 a barrel down to \$11, there isn't a comparable reduction?

26 I didn't bring the letter with me today because I didn't
27 want to bore you or the Committee with it. You have a copy of
28 the letter they wrote back to me.

1 It's all just gobbledygook, and it doesn't say anything
2 that's relevant to the letter, and doesn't justify the position,
3 other than to say: There's more than oil to the rate setting;
4 there's nuclear; there's hydroelectric. But those things were
5 all there when the rates were going up.

6 MR. HULETT: Right.

7 SENATOR MELLO: And the public is losing faith in our
8 rate setting concept, and Sylvia Siegel, who's not here, but if
9 not for her, this dear little person who's going out there -- she
10 represents mainly the domestic person.

11 MR. HULETT: That's correct.

12 SENATOR MELLO: And she's won millions of dollars, I
13 think you'd have to admit yourself, through her efforts there's
14 been millions of dollars reduced. So, without her, our rates
15 would even be higher.

16 But it's moving into the commercial and industrial area
17 now. I just don't think even large rate payers can afford to
18 send or even bond together to try to do something about their
19 rates.

20 The reason I wrote you the letter is that I cannot
21 explain to my constituents why the rates aren't coming down as
22 they went up over the last ten years. There's no answer. And
23 your Commission has not given us an answer either.

24 MR. HULETT: No, you've not had a satisfactory answer.
25 I saw the answer, and I don't agree with you that it was not
26 satisfactory.
27
28

1 One thing that has not been mentioned is the fact that
2 in fact we have reduced the PG&E rates very substantially within
3 the last 30 days: 10 percent to the larger users; 5 percent to
4 agriculture and the smaller users. We also reduced the gas rates
5 substantially.

6 SENATOR MELLO: Why were they reduced? Because you have
7 an abundance of water this year for hydroelectric power? Is that
8 the reason?

9 MR. HULETT: As I say, we did make an interim reduction
10 of 10 percent.

11 SENATOR MELLO: You have the oil prices reducing. I
12 think that's justified. It's probably what the rate payer's
13 looking for a lot more than 5 percent.

14 MR. HULETT: I agree.

15 SENATOR MELLO: Rates have gone up about 500 percent, or
16 maybe a thousand percent, and now to get 5 or 10 percent
17 reduction is nothing. There are people going out of business
18 right now that can't afford to pay their energy bill.

19 MR. HULETT: You're absolutely correct. Normally the
20 way this has been done, it's been done on an annual basis, and it
21 was determined that we wanted to make an interim reduction
22 because it was so clear that there needed to be a reduction
23 immediately. So we made an interim reduction; there will be
24 further reductions later this year. And I suspect that as we
25 move into next year, provided these fuel prices stay where they
26 are and it appears there's not going to be a large fly up in
27 those rates, that there will be further reductions.

1 You put your finger on something, I think, that's
2 terribly important, Senator, and that is the faith that the
3 people have in the rate making body. I agree, and I found it
4 difficult, even as a Member of the Commission with professional
5 staff to help me understand what was going on, what it was that
6 we were doing. And I can understand how the average person who
7 gets his bill and looks at it and says: What does this mean?

8 We've got to do a better job of letting the public know
9 what it is we're doing and why we're doing it.

10 SENATOR MELLO: I think what's going to happen is, I
11 think it's too late for this year, but I think we're going to see
12 on the ballot an initiative. People are getting so made they're
13 going to launch an initiative to change our whole rate making
14 authority and put it into some other concept. Hopefully we won't
15 jump into a worse situation. But I think they're at a point
16 where they're going to turn to some other means, because I think
17 they've lost faith in the Legislature, and they've lost faith in
18 the Commission to get fair and equitable rates based on the cost
19 of operation.

20 I just hope you can do the job that you claim you'll be
21 sympathetic to and help turn this thing around.

22 MR. HULETT: We're certainly going to try, and if I come
23 away with this after the end of my term, and I have helped
24 simplify this process and at least made the public understand
25 what it's all about, I will feel I've accomplished something.

26 CHAIRMAN ROBERTI: We've been joined by Senator Herschel
27 Rosenthal who'd like to ask Mr. Hulett some questions.
28

1 MR. HULETT: Senator.

2 SENATOR ROSENTHAL: I got here a little bit late, and I
3 understand that you did express some viewpoints regarding what
4 the companies were doing with their monies that they don't have
5 to reinvest now into their own businesses.

6 Couple of other brief questions. There are several
7 states that are opening up their states to total competition in
8 the telecommunications area.

9 Do you think that we should do that type of thing in
10 California?

11 MR. HULETT: Well, I'm troubled by that kind of
12 competition only in that I'm afraid you would have such
13 proliferation of companies, and you know, you'd have one phone
14 company serving you, one phone company serving your next-door
15 neighbor. I would think we would find that that would become
16 technically infeasible.

17 But I do think what we must do is to make sure that
18 those companies that have franchise areas or monopoly areas are
19 -- are serving their customers and serving them properly, and
20 serving them at rates they can afford.

21 SENATOR ROSENTHAL: How can we prevent utilities, or
22 should we, from dominating the third party energy market and thus
23 eliminating the competition?

24 There's a lot of questions now being raised by the
25 Energy Commission and the PUC in looking at some of those
26 problems, and I just wonder what you think about that competitive
27 market.
28

1 MR. HULETT: The competitive market has been very
2 helpful. This is the so-called cogeneration, or qualifying
3 facilities area. And it's an area where you find someone has a
4 need for steam, or a need for electricity, or a need for both,
5 but it's excess to their needs and they're able to sell a certain
6 amount of that back to the utility under a federal law.

7 I think that competition has been a good force. It's
8 been important in California because it has caused us to take a
9 look at the need to build very costly, very large central
10 generating facilities in this state, and forced us rather to look
11 at opportunities by smaller producers, such as you're suggesting.

12 I don't really see anything wrong with the utilities
13 participating in the financing of these smaller units, because
14 what it does then is gives them some control over the
15 dispatchability (sic.) and the time and hours of service so that
16 it meets the hours of demand by the consumers in that area.

17 SENATOR ROSENTHAL: Mr. Chairman, I guess the other
18 couple of things that I wanted to ask have already been discussed
19 by the Committee.

20 I hope the Rules Committee will recommend confirmation
21 of Mr. Hulett. Though we don't agree on all things, I think he's
22 an independent thinker. I've had occasion to have some
23 conversations with him on issues as they have come up during this
24 year.

25 He understands the Legislature, and I think he'll be
26 sensitive -- at least I hope he'll be sensitive -- to our
27 concerns about protecting the constituents and utility rate
28 payers.

1 With that, I don't have any other questions. I am
2 concerned about the issue that Senator Mello raised, trying to
3 explain why rates are going up as oil prices are going down. We
4 have talked about that in terms of how difficult it is to come up
5 with an easy answer, because you have all kinds of problems
6 related to it in terms of the larger users going off the system
7 as oil prices went down, which means that the bottom line is the
8 same costs, and so the home owner rate goes up even though the
9 price of oil is going down.

10 There needs to be a quicker reaction. In other words,
11 we have no problem when oil prices are going up, we raise the
12 rates. But there needs to be a quicker reaction and a better
13 explanation to the public as to what's happening as the oil
14 prices are coming down, why their rates haven't come down as
15 rapidly.

16 I'm not sure that that's an easy subject to explain to
17 anybody, but we have discussed it, and I feel confident to offer
18 my support and a lot of luck to this fellow who's taking on a
19 tough job.

20 MR. HULETT: Senator, thank you very much. I appreciate
21 your support, and I look forward to further conversations on how
22 we can do a better job of representing the public interest.

23 CHAIRMAN ROBERTI: Thank you very much, Senator.

24 Are there any further questions?

25 VICE CHAIRMAN CRAVEN: Mr. Chairman, I would move the
26 confirmation of Mr. Hulett to both Commissions.
27
28

1 CHAIRMAN ROBERTI: Senator Craven moves Mr. Hulett's
2 confirmation both to the Public Utilities Commission and the
3 California Transportation Commission.

4 Is there any opposition? Seeing none, Secretary will
5 call the roll.

6 SECRETARY WEBB: Senator Doolittle. Senator Mello.

7 SENATOR MELLO: Aye.

8 SECRETARY WEBB: Senator Petris.

9 SENATOR PETRIS: Aye.

10 SECRETARY WEBB: Senator Craven.

11 VICE CHAIRMAN CRAVEN: Aye.

12 SECRETARY WEBB: Senator Roberti.

13 CHAIRMAN ROBERTI: Aye.

14 The vote is four to nothing; confirmation is recommended
15 to the Floor on both appointments.

16 Thank you very much.

17 MR. HULETT: Thank you very much, Mr. Chairman and all
18 Senators. Thank you very much.

19 CHAIRMAN ROBERTI: We are going to proceed through our
20 calendar as it is in our agenda. That means we will continue
21 with the agenda, and that is the Governor's Appointees. After
22 that we will take rule waivers.

23 We have one more Appointee of the Governor, Janice
24 Mondavi, Member of the California Regional Water Quality Control
25 Board, San Francisco Bay Region.

26 MS. MONDAVI: Thank you.

27

28

1 CHAIRMAN ROBERTI: Ms. Mondavi, we'll ask you the
2 question we ask all the Governor's Appointees, and that is why
3 you feel you are qualified to assume this position.

4 MS. MONDAVI: Thank you, Mr. Chairman, Members of the
5 Board.

6 I do own and operate -- my name is Janice Mondavi.
7 Excuse me, it's my first time to be confirmed for anything.

8 SENATOR PETRIS: Can we bring you a little wine?

9 MS. MONDAVI: I should have had a glass at lunch, thank
10 you.

11 (Laughter.)

12 MS. MONDAVI: I do own and operate a food manufacturing
13 company. It's a small one, but it does use industrial water for
14 its sanitation purposes as well as production facilities. It is
15 a cheese company.

16 I'm also affiliated with a much larger company owned by
17 my husband's family. And of course, when you're married to a
18 business, you know quite a bit about what goes in and out of the
19 business. That's the Charles Krug Winery, and it too uses
20 probably about 2½-3 million gallons of water on an annual basis.

21 I have had some political background in my brief
22 history, and I do feel that I have the dedication and a fairly
23 sound business and ecological approach to water conservation in
24 the Bay Area.

25 CHAIRMAN ROBERTI: Thank you.

26 Are there any questions?

27 How long have you been on the Board?
28

1 MS. MONDAVI: I've been sitting on the Board now since
2 September, ten months.

3 CHAIRMAN ROBERTI: Right now what is the Regional Board
4 doing to expedite ground water cleanup on the Superfund sites?
5 What is the program policy?

6 MS. MONDAVI: Right now for the ground water Superfund
7 projects we are requiring some of the individuals to contain the
8 plumes of the ground water. We're requiring them also to extract
9 the water, treat it, and then either put it back into the runoff
10 so it will go back down in, or back down into the well system.

11 There are a number of -- well, go on.

12 CHAIRMAN ROBERTI: How do you decide if your Board or
13 the Department of Health Services should take the lead role in
14 Superfund cleanup?

15 MS. MONDAVI: We work hand in hand with them. Normally
16 we --

17 CHAIRMAN ROBERTI: Who initiates?

18 MS. MONDAVI: They are usually notified of the problem,
19 and then they notify our Board, and then we take the action and
20 make the enforcement policies from there.

21 CHAIRMAN ROBERTI: Do you think you have sufficient
22 staff on your Board to administer the program?

23 MS. MONDAVI: Yes, I feel our staff is very qualified,
24 especially in the technical end, where they advise our Board and
25 advise the public and act as the prosecutor, you might say, in
26 some instances. Our feel our Board acts as a judge to try and
27 determine whether our staff's information is accurate or the
28 individual's information is more accurate.

1 If at that point we don't feel that we have the
2 knowledge, we do refer it to the Attorney General and have in a
3 number of cases.

4 CHAIRMAN ROBERTI: Do you have a position on the waste
5 discharge permit for the I.T. Benecia hazardous disposal site?

6 MS. MONDAVI: I can't say I know that fully in detail.

7 CHAIRMAN ROBERTI: Have you had to vote on that yet at
8 any stage of the proceedings?

9 MS. MONDAVI: I'm not sure, Senator.

10 CHAIRMAN ROBERTI: To the best of your knowledge,
11 probably, the Board hasn't been intricately involved in that
12 matter yet?

13 MS. MONDAVI: It comes before the Board, the issues are
14 presented, and then we make our decision and it's carried on.
15 Our staff from there implements it, and then we usually get a
16 status report on that a month or two months later.

17 CHAIRMAN ROBERTI: Any further questions of Ms. Mondavi?
18 Is there any opposition in the audience?

19 VICE CHAIRMAN CRAVEN: Move Ms. Mondavi's confirmation.

20 CHAIRMAN ROBERTI: Senator Craven moves confirmation of
21 Janice Mondavi to the Floor be recommended.

22 Secretary will call the roll.

23 SECRETARY WEBB: Senator Doolittle. Senator Mello.

24 SENATOR MELLO: Aye.

25 SECRETARY WEBB: Senator Petris.

26 SENATOR PETRIS: Aye.

27 SECRETARY WEBB: Senator Craven.
28

1 VICE CHAIRMAN CRAVEN: Aye.

2 SECRETARY WEBB: Senator Roberti.

3 CHAIRMAN ROBERTI: Aye.

4 The vote is four to nothing; confirmation is recommended
5 to the Floor.

6 (Thereupon this portion of
7 the Senate Rules Committee
8 hearing was terminated at
9 approximately 2:50 P.M.)

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I, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Senate Rules Committee hearing was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this

14th day of July, 1986.


EVELYN MIZAK
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26 Evelyn Mizak
27 Shorthand Reporter
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SENATOR DAVID ROBERTI, Chairman

SENATOR WILLIAM CRAVEN, Vice-Chairman

SENATOR JOHN DOOLITTLE

SENATOR HENRY MELLO

SENATOR NICHOLAS PETRIS

STAFF PRESENT

CLIFF BERG, Executive Officer

PAT WEBB, Committee Secretary

RICK ROLLENS, Consultant on Bill Referrals

NANCY MICHEL, Consultant on Appointments

ALSO PRESENT

BILL BUNNELL, Superintendent,
California Correctional Institution at Tehachapi

LOUIS STEVE PORTER, Member,
Public Employment Relations Board

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Committee Action

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LOUIS STEVE PORTER, Member,
Public Employment Relations Board

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Motion

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Committee Action

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Termination of Proceedings

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Certificate of Reporter

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P R O C E E D I N G S

--oo0oo--

CHAIRMAN ROBERTI: Governor's Appointees appearing today, Mr. Bill Bunnell, Superintendent of the California Correctional Institution at Tehachapi.

MR. BUNNELL: My name is Bill Bunnell.

CHAIRMAN ROBERTI: Mr. Bunnell, we'll ask you the question we ask all the Governor's Appointees: Why you feel you're qualified to assume this position?

MR. BUNNELL: Thank you, sir.

I've been employed by the State of California for 38-plus years, the past 38-plus years. The last 28 years of this employment has been with the Department of Corrections. During this period of time I have worked in seven institutions and have held various supervisory managerial positions. These positions include business services support positions as well as custodial positions.

On April 22nd, 1985, I was assigned acting Superintendent at the California Correctional Institution at Tehachapi. Since that period of time we have increased our population in our Unit I and Unit II, as well as activate the first phase of our new maximum facility. We are in the process of planning the activation of the second phase of the maximum facility, known as Unit IV B approximately sometime in March.

We have also under construction at Tehachapi what is commonly called a quick bill Level III facility which we plan to occupy July 1st, 1986.

1 I feel that with my background I have the knowledge and
2 experience that is required to be the Superintendent at the
3 California Correctional Institution at Tehachapi.

4 CHAIRMAN ROBERTI: Very good.

5 Any questions of Mr. Bunnell?

6 Seeing none, Mr. Bunnell, I've read your resume and the
7 recommendation. You're an outstanding appointee, so we don't
8 really have any questions to ask you. We think you're doing a
9 very good job at Tehachapi.

10 SENATOR CRAVEN: Move Mr. Bunnell's confirmation to the
11 Floor.

12 CHAIRMAN ROBERTI: Senator Craven moves Mr. Bunnell's
13 confirmation be recommended to the Floor.

14 Any objection?

15 Hearing none, Secretary will call the roll.

16 SECRETARY WEBB: Senator Doolittle.

17 SENATOR DOOLITTLE: Aye.

18 SECRETARY WEBB: Senator Mello.

19 SENATOR MELLO: Aye.

20 SECRETARY WEBB: Senator Petris.

21 SENATOR PETRIS: Aye.

22 SECRETARY WEBB: Senator Craven.

23 SENATOR CRAVEN: Aye.

24 SECRETARY WEBB: Senator Roberti.

25 CHAIRMAN ROBERTI: Aye.

26 The vote is five to nothing; confirmation is recommended
27 to the Floor.
28

1 Mr. Louis Steve Porter, Member of the Board of Public
2 Employment Relations.

3 Mr. Porter, we'll ask you the same question we asked Mr.
4 Bunnell: Why you feel you're qualified to assume this position?

5 MR. PORTER: Well, I think probably the main function of
6 a PERB Board member is reviewing administrative cases that have
7 been appealed to the Board, finding the facts in the pleadings
8 and administrative transcripts and hearings, and applying the
9 applicable law to them.

10 I think various aspects of my education and work
11 experience are helpful in that connection. I've been in public
12 service for some 37 years now, a little over eight years as a
13 police officer for the City of Berkeley, where I received
14 training and experience in finding facts and separating out facts
15 from opinion and making factual determinations.

16 While on the police department I attended law school in
17 which part of the elemental training there, of course, is to
18 analyze in any situation the significant facts and to apply the
19 applicable law to them.

20 I was, for three and a half years, a deputy district
21 attorney for the County of Contra Costa, which again involved on
22 many occasions determining what the facts were on many cases and
23 applying the applicable law. A year and a half for the State
24 Real Estate Commissioner, where I got my baptism in
25 administrative law cases, dealing again with determining what the
26 facts were in a case and applying the law.

27
28

1 In the spring of 1963 I joined the State Attorney
2 General's Office. I was with the Attorney General's Office until
3 my appointment last year to the Board. My first ten or twelve
4 years as working deputy were primarily doing administrative law
5 cases, handling administrative law agencies.

6 I think that my general education, general background,
7 is helpful in what really is the day-to-day workings of the PERB
8 Board. That is reviewing administrative law cases, the agency
9 cases brought to the Board on appeal, and making decisions on
10 them.

11 CHAIRMAN ROBERTI: Any questions of Mr. Porter?

12 Seeing none, any opposition in the audience?

13 Seeing none, Mr. Porter, you're getting off easy.

14 Secretary will call the roll.

15 SENATOR CRAVEN: Move, Mr. Chairman.

16 CHAIRMAN ROBERTI: Senator Craven moves.

17 SECRETARY WEBB: Senator Doolittle.

18 SENATOR DOOLITTLE: Aye.

19 SECRETARY WEBB: Senator Mello.

20 SENATOR MELLO: Aye.

21 SECRETARY WEBB: Senator Petris.

22 SENATOR PETRIS: Aye.

23 SECRETARY WEBB: Senator Craven.

24 SENATOR CRAVEN: Aye.

25 SECRETARY WEBB: Senator Roberti.

26 CHAIRMAN ROBERTI: Aye.

27

28

1 The vote is five to nothing; confirmation is recommended
2 to the Floor.

3 Congratulations.

4 (Thereupon this portion of the Senate
5 Rules Committee hearing was terminated
6 at approximately 2:30 P.M.)
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CERTIFICATE OF SHORTHAND REPORTER

1, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Senate Rules Committee hearing was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this 18th day of February, 1986.


EVELYN MIZAK
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APPEARANCES

MEMBERS PRESENT

SENATOR DAVID ROBERTI, Chairman

SENATOR WILLIAM CRAVEN, Vice-Chairman

SENATOR HENRY MELLO

SENATOR NICHOLAS PETRIS

MEMBERS ABSENT

SENATOR JOHN DOOLITTLE

STAFF PRESENT

CLIFF BERG, Executive Officer

PAT WEBB, Committee Secretary

RICK ROLLENS, Consultant on Bill Referrals

NANCY MICHEL, Consultant on Appointments

ALSO PRESENT

NORMAN BARKER, Jr., Member
State Teachers' Retirement Board

RONALD E. KOENIG, Member
Board of Prison Terms

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P R O C E E D I N G S

--oo0oo--

CHAIRMAN ROBERTI: Governor's Appointees appearing today, first will be Mr. Norman Barker, Jr., Member of the State Teachers' retirement Board.

Mr. Barker, we'll ask you what we ask all the Gubernatorial Appointees: Why do you feel you're qualified to maintain this position?

MR. BARKER: Thank you, Senator.

My career has been primarily oriented in the finance area. I did my graduate and undergraduate work at the University of Chicago with a degree in economics, and I started my banking career there. I started as a security analyst, and while in my later career I was in commercial banking I always was involved in trust investments.

That's the aspect that I feel most qualified for in the service that I may offer to the State Teachers' Retirement Fund. There is a historical fact that my father was a beneficiary of the State Teachers' Retirement Fund, so I feel an emotional tie to it also.

CHAIRMAN ROBERTI: Thank you very much, Mr. Barker.

Are there any questions of Mr. Barker? Is there any opposition in the audience?

SENATOR CRAVEN: I would move Mr. Barker's confirmation.

CHAIRMAN ROBERTI: Senator Craven moves Mr. Barker's appointment be recommended to the Floor do pass.

1 We all know of your outstanding qualifications, so we're
2 happy to cast an affirmative vote.

3 Secretary will call the roll.

4 SECRETARY WEBB: Senator Doolittle. Senator Mello.
5 Senator Petris.

6 SENATOR PETRIS: Aye.

7 SECRETARY WEBB: Senator Craven.

8 SENATOR CRAVEN: Aye.

9 SECRETARY WEBB: Senator Roberti.

10 CHAIRMAN ROBERTI: Aye.

11 The vote's three to nothing; the nomination of Mr.
12 Barker is recommended to the Floor do pass.

13 MR. BARKER: Thank you very much.

14 CHAIRMAN ROBERTI: Thank you.

15 Mr. Koenig, our next Appointee, is not here yet, so we
16 will do rule waivers awaiting his arrival.

17 (Thereupon the Committee took
18 up other agenda items.)

19 CHAIRMAN ROBERTI: We have with us Ronald E. Koenig,
20 Member of the Board of Prison Terms.

21 Please come forward. We'll ask you what we ask all the
22 Governor's Appointees, and that is why you feel you're qualified
23 to assume this position?

24 MR. KOENIG: Thank you Mr. Chairman, Members of the
25 Senate Rules Committee.

26 I appreciate the opportunity to be here this afternoon
27 for the purposes of confirmation as a Member of the Board of
28 Prison Terms.

1 It appears, as I sit here, that my entire career has
2 been directed towards this afternoon. Enforcing the laws of the
3 State of California and protecting our citizens from those people
4 who do not abide by the rules of our society has encumbered 27
5 years of my life, beginning with the California Highway Patrol in
6 1958, and then as the elected Sheriff of Tehama County for three
7 terms.

8 The people in Tehama County elected me first in 1974,
9 again in 1978, and once again in 1982. And it was only because
10 of the prestigious appointment by the Governor and I left Tehama
11 County to assume the position as Chairman of the Board of Prison
12 Terms.

13 During the three terms as Sheriff, I directed the
14 operations and built a professional law enforcement agency in
15 Tehama County. I directed the building of a new jail facility up
16 in that county, and I became extremely involved in corrections,
17 not only on the local level but on the state level.

18 I also, during that period of time, participated in the
19 many committees throughout the State of California. I
20 participated in the Crime Resistance Task Force for the Governor
21 for the last three years, the Attorney General's Rural Crime Task
22 Force, also chaired for two years the Retention and Correction
23 Committee for the California Peace Officers' Association, and
24 chaired for two years the California State Sheriffs' Jail
25 Committee.

26 I'm especially honored to be appointed to this position
27 because I'm the first Sheriff of the State of California ever
28

1 appointed to the California State Parole Board. And as you
2 gentlemen know, many of the duties that I have and that the Board
3 has has to do with working with our 58 California Sheriffs.
4 Knowing them, working with them, knowing their problems is
5 immensely important if we are going to help in solving the many
6 problems we have in Corrections today.

7 For the last nine months, I have been -- I accepted the
8 duties as Chairman of the Board of Prison Terms, thus I became
9 the administrative head of the Board, responsible for seeing that
10 the statutory duties are carried out.

11 For these reasons I feel that I am qualified for the
12 position.

13 Thank you, Mr. Chairman.

14 CHAIRMAN ROBERTI: Thank you very much, Mr. Koenig.

15 Are there any questions of Mr. Koenig? Is there any
16 opposition in the audience?

17 I think there are a number of people in support in the
18 audience. Why don't we handle it this way; why don't you stand
19 up so we can see.

20 Well, I think it's a rather unanimous group.

21 Let me add that there have been a whole slough of
22 accusations made. Quite frankly I have never been so unimpressed
23 by really slanderous accusations, in my mind, without any
24 substantiation, as were the ones that were made continuously
25 against you and your character.

26 So, to indicate how highly I view those
27 characterizations, I'm not going to ask you any questions.
28

1 Are there any questions of Mr. Koenig? Senator Petris.

2 SENATOR PETRIS: I'm concerned about communication
3 between the Board and the Department of Corrections. Inevitably
4 over the years there's some differences of style and opinion as
5 to who does what, and how well they communicate.

6 What in your view is the status of that now? Does the
7 Board get along well with Corrections in various policy matters
8 that they have to confer about? Do you see any obstacles right
9 now?

10 MR. KOENIG: No, I don't see any obstacles right now.
11 We are working very closely with the agency and with the
12 California Department of Corrections. We met regularly with that
13 agency, with the California Department of Corrections, Mr.
14 McCarthy, and with agency themselves.

15 We are working very positively, particularly in the area
16 of reducing the prison population, looking for ideas to reduce
17 it. I think that we're coming up with some fairly good ideas.

18 SENATOR PETRIS: I understand there's a problem on the
19 question of parole violations. The Department is apparently
20 considering changing the criteria under which they would forward
21 to you information about parole violations. And the Department
22 last year was accused of not returning enough information to your
23 Board of repeated drug offenders for action.

24 Is there anything pending on that?

25 MR. KOENIG: I know it was said to be a problem in the
26 past. I see no problem whatsoever in the period of time that
27 I've been there.

1 I'd like to hear your response if that is true, and why
2 you loaned them a scanner. I've heard before that scanners are
3 what the burglars use when they can pick up a police car that's
4 about to track them down, and they know that the fuzz is coming,
5 so to speak.

6 MR. KOENIG: Yes, I did loan a scanner to a tavern in
7 Gerber in 1982. And of the 10-20 major decisions I made as
8 Sheriff in the County, probably that's one decision I would make
9 differently, particularly now.

10 In a rural county you have a problem -- the biggest
11 problem we have is within our bar establishments, our taverns:
12 fights, stabbings, even shootings. In fact a year or two prior
13 we had a double shooting just about three miles down the road.

14 It is the duty of the Sheriff to build a rapport between
15 the tavern owner and law enforcement. It's a preventive measure
16 so that if the bar owner or the bartender sees a problem building
17 up within his tavern, he calls law enforcement before the actual
18 problem exists -- takes place; before we have a stabbing or a
19 murder.

20 I had made it a practice in my county to make sure that
21 I knew all the tavern owners, that I worked with them, that I
22 built this credibility between them and law enforcement. My
23 deputies were ordered to go through the bar at least twice during
24 their shift to prevent problems from occurring.

25 This particular tavern's owners, the proprietors of this
26 tavern, alleged and accused us of setting on the bar, picking on
27 their particular people, and creating the loss of business.
28

1 We are making some changes in the -- in looking at some
2 possibilities to, as I say, in the parole population, a way to
3 reduce the parole population. We're coming up with some ideas.

4 One of the ideas that we are looking at is the
5 possibility of holding a progress hearing for a parolee once
6 they are returned back to prison for a violation of the
7 conditions of their parole. A possibility after -- if they, for
8 instance, are given 9-12 months, to look at them after 3-6
9 months as a parolee. If they are of the type of prisoner or
10 parolee of the nonviolent type, to look at how they've performed
11 in prison since they've been returned, and the possibility of an
12 early release at that particular time.

13 We feel that this may be a way to go, but we're looking
14 at it and studying it along with the California Department of
15 Corrections and the agency.

16 SENATOR PETRIS: Who do you think should take the
17 initiative on reviewing an accusation of a parole violation of a
18 serious offender, a felon who's out on parole?

19 MR. KOENIG: We have a procedure, of course, set up now.
20 The Parole Division of the California Department of Corrections
21 are the ones who look at the parolee and make the arrest, or
22 local law enforcement, and suggest -- recommended to us, or at
23 least advise us of the allegation.

24 One of the statutory responsibilities that the Board of
25 Prison Terms has, of course, is to hold a hearing, conduct a
26 hearing for the parolee, first of all to make -- find out if in
27 fact the allegation is true. And if that's the case, then to
28

1 decide whether that parolee should go back to prison or remain
2 on parole.

3 And I think the system that is working now is a good
4 system. It's just that any problems that we may have, and I see
5 very few, have to do with the tremendous load that we have, not
6 only in the prison population but in the parole population.

7 SENATOR PETRIS: Do you have to subpoena people
8 sometimes to come into the hearing?

9 MR. KOENIG: Very definitely, witnesses.

10 SENATOR PETRIS: Are you using that --

11 MR. KOENIG: Yes, we are.

12 SENATOR PETRIS: -- to the extent it's necessary?

13 MR. KOENIG: Yes, very definitely.

14 SENATOR PETRIS: Thank you.

15 CHAIRMAN ROBERTI: Senator Mello.

16 SENATOR MELLO: Thank you, Mr. Chairman.

17 I know there are a lot of innuendoes and other
18 background information that was given to us. As Senator Roberti
19 said, most of them are apparently without merit.

20 But there are some incidents that were from our own
21 staff and background information that I would just like to ask
22 you a couple of questions about:

23 One of them is the loaning of a scanner from your office
24 to a bar in Gerber called the B & B Tavern. I guess this took
25 place.

26 It doesn't seem like a Sheriff would be loaning a
27 scanner out to anybody, especially if it's equipment that's
28 bought by the County with public funds, to a private individual.

1 I'd like to hear your response if that is true, and why
2 you loaned them a scanner. I've heard before that scanners are
3 what the burglars use when they can pick up a police car that's
4 about to track them down, and they know that the fuzz is coming,
5 so to speak.

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24 during their shift to prevent problems from occurring.

25 This particular tavern's owners, the proprietors of this
26 tavern, alleged and accused us of setting on the bar, picking on
27 their particular people, and creating the loss of business.
28

1 On several occasions I tried to assure them that this is
2 not true. And finally I said: Hey, look, you should know
3 what's going on throughout the county. We don't make arrests
4 only in the city of Gerber, the unincorporated area of Gerber,
5 but throughout the county. And I said: In fact, the -- my
6 policy from the time I began the term as Sheriff was that the
7 deputy sheriffs do arrest drunk drivers. In fact, from
8 1977-1982, the department of -- my department had the highest
9 drunk driving arrests of any agency in the county. In 1982, we
10 had 135 drunk driver arrests, which surpassed all the agencies
11 including the California Highway Patrol.

12 And in order -- and I told the proprietor that: I want
13 you to see that we're not just sitting on your bar; we're not
14 just singling you out. We are arresting people throughout the
15 county.

16 I said: Use my scanner. You can use it to see that the
17 deputies aren't just sitting here; they're making their arrests
18 throughout the county.

19 That was the reason for it.

20 SENATOR MELLO: But as a general practice, I guess, you
21 said you regret making that loan.

22 I'm really questioning the appropriateness of a sheriff,
23 the chief law enforcement of a county, to loan public equipment
24 such as scanner to a private individual, even though his claim
25 might be that you were picking on that person. I just can't see
26 how appropriate it would be to provide that scanner to anyone
27 making that kind of complaint.
28

1 But I guess you regret doing it.

2 Is that the only case where you loaned equipment like
3 that to a private person?

4 MR. KOENIG: There are other agencies throughout the
5 state, and I have a witness here, Senator, that will relate
6 that this county also used loaned county equipment.

7 The county equipment, although it's county equipment, is
8 the Sheriff's property through the people. I had the authority
9 to loan equipment if it's in the course of law enforcement; if
10 it's going to do law enforcement some good. And in this case,
11 I felt very strongly, definitely at that particular time, that
12 it would do us some good, that it would prevent problems from
13 occurring within that bar establishment.

14 SENATOR MELLO: I've had law enforcement in my county
15 ask me to introduce bills to outlaw the private use of scanners
16 and other use on that frequency because they feel that many of
17 the persons that are into crime all monitor the police bands,
18 and therefore it works against law enforcement to have these
19 kinds of equipment out there.

20 MR. KOENIG: Right. And certainly it's not against the
21 law to possess a scanner or to use a scanner.

22 I think you'll find in rural counties particularly,
23 where there's not a lot of entertainment going on, the scanner
24 has almost become an entertainment instrument. Many people --
25 most businesses have them, bars, liquor stores, particularly
26 your private individuals. A lot of them, that's their enter-
27 tainment even over television. They go to bed with a scanner.
28

1 SENATOR MELLO: They can buy them. You can go down to
2 Radio Shack is buy them, but I think in this case here, very few
3 people have scanners furnished them by the local law enforcement
4 entity. I mean, that's my experience in my area.

5 MR. KOENIG: Yes, I agree with you, Senator.

6 SENATOR MELLO: I want to pursue another question that
7 relates to a gun permit that was issued to Charles Cobb.

8 MR. KOENIG: Yes.

9 SENATOR MELLO: And it appears that this Mr. Cobb
10 allegedly committed battery on his wife, Jeanette, June 14th,
11 1981. Four or five days later, she obtained a restraining order
12 under the Domestic Violence Act against Mr. Cobb. Then about
13 ten days after that, June 29th, 1981, Cobb was issued a gun
14 permit signed by yourself, Sheriff Ron Koenig.

15 As the events went on, on September 2nd, Cobb committed
16 battery on Jeanette Cobb Holsinger, his wife. On September 9th,
17 Cobb was arrested for cultivation of marijuana and battery.
18 Approximately \$100,000 worth of marijuana was confiscated.

19 There's a whole series of events:

20 "On October 14th, proceedings were
21 suspended on the battery and Cobb
22 was placed under a diversion program.
23 During June, 1982, the cultivation
24 charges were dismissed based on lack
25 of probable cause to search Cobb's
26 property. On August 9, the diversion
27 program was terminated and the battery
28 charge against Cobb was dismissed."

1 In 1984, and this is the one:

2 "On January 19, 1984, Cobb's gun
3 permit was reissued and was signed
4 by Sheriff Ron Koenig."

5 MR. KOENIG: Yes, that's true.

6 In 1977, the procedure as set up by the prior Sheriff
7 was that the administrative sergeant would issue the concealed
8 weapons permit, and that was the procedure until late in '77.
9 Sometime in '77 I changed that procedure.

10 The original gun permit to Mr. Cobb was issued by
11 Sergeant Carmichael, who was the administrative sergeant at that
12 particular time, and I had no knowledge of the issuance. He
13 issued them by -- legally as is required -- by sending it to the
14 Department of Justice to search the background and send it back.

15 SENATOR MELLO: A question on that point.

16 Doesn't the Sheriff have the right to suspend any issued
17 gun permits that were issued by a previous sheriff?

18 MR. KOENIG: Yes, sir.

19 SENATOR MELLO: Even by himself?

20 MR. KOENIG: Yes, sir.

21 But what I'm saying is, that was the procedure, that the
22 administrative sergeant, or the administrative head, could issue
23 the gun permit.

24 Late in '77 I changed that procedure, that only the
25 Sheriff, the Undersheriff, or the Captain in the Sheriff's
26 absence could issue the concealed weapon's permit.

27

28

1 Mr. Cobb had the concealed weapon's permit without my
2 knowledge at that particular time. When he was arrested in 1981
3 by the Tehama County Sheriff's Department for cultivation of
4 marijuana, he had in his possession, without my knowledge, the
5 concealed weapon's permit. He did not come in and renew it in
6 1982 and 1983. He renewed it again in 1984.

7 SENATOR MELLO: Could I go back to that point again.

8 MR. KOENIG: Yes.

9 SENATOR MELLO: When he was arrested on September 9th,
10 1981, for cultivation of marijuana, you said you were not aware
11 that he had a gun permit?

12 MR. KOENIG: No.

13 SENATOR MELLO: Even though according to our information
14 you issued him a permit on June 29th, 1981, signed by yourself,
15 and that was about three months prior to his arrest?

16 MR. KOENIG: Okay, the administrative procedure was that
17 the Sheriff issued original permit after 1977, after Mr. Cobb
18 received his first permit. After that, for renewal of the gun
19 permit -- and this isn't only Tehama County; many, many sheriffs
20 in the state have this same procedure -- the permits are signed
21 and given to the administrative section, and they then, when a
22 renewal comes in, they simply come in and renew the permit. A
23 check is run later on his background, other than the original
24 background, but whether he has committed a felony prior to that
25 -- during that year, and then it's issued by the administrative
26 area.

1 The Sheriff has nothing to do with that, with the
2 issuance of that permit or the reissuance of that permit.

3 SENATOR MELLO: The administrative unit in your own
4 Sheriff's office?

5 MR. KOENIG: Yes, right.

6 SENATOR MELLO: You say you don't have anything to --

7 MR. KOENIG: No, the only time I know about the fact
8 that the man may not -- should not have the permit is if he gets
9 in some type of problems within the county or within the state,
10 and I am to be notified by the administrative section that this
11 man has committed a felony, or has committed a violent
12 misdemeanor. And then I would ask -- the man would be written a
13 letter, and I would re-interview him and probably pull the
14 permit.

15 SENATOR MELLO: I was a county supervisor at one time,
16 and I worked closely with the sheriff of my own county. And
17 when he came in, he suspended all of the private gun permits
18 that were out. He felt that it undermines his own deputies to
19 have a bunch a private citizens out there with permits issued by
20 the sheriff because it's tough enough dealing with the criminals
21 out there, let alone people who really don't know, nor are they
22 deputized to use a gun.

23 Just how widespread under your term of sheriff, how many
24 permits were they issuing to private citizens to carry a gun in
25 Tehama County?

26 MR. KOENIG: I don't know the exact number. I would say
27 around 400-500 within the county, permits.

1 SENATOR MELLO: Then the point I covered before, after
2 your knowledge of all of this involvement with Mr. Cobb and his
3 alleged wife beating, and the arrest for cultivation of
4 marijuana, and so forth, it seems a little surprising that you
5 would reissue a gun permit to him a couple years later.

6 MR. KOENIG: I didn't personally reissue it, Senator.
7 Again, the permits are signed; they're given 15 or 20 at a time
8 to the administrative section. The permittee who has an
9 original permit comes in and renews his permit each year, as is
10 by law.

11 That permit -- he did not renew his permit in 1982 and
12 '83. In 1984, he came back and renewed his permit through the
13 administrative process. It was simply a breakdown in the
14 administrative area that did not notify me at that particular
15 time.

16 I did not know that Mr. Cobb had a concealed weapon's
17 permit, Senator, until Mr. Beren from the Department of Justice
18 interviewed me in December of 1985 as a result of my requesting
19 an investigation by the Department of Justice. When he told me
20 at that particular time, or asked me that Mr. Cobb had a
21 concealed weapon's permit, that was new to me. I did not
22 realize -- I didn't know at that particular time that he had one
23 because I was never involved at any time in the actual issuance
24 of that permit.

25 SENATOR MELLO: I'm not familiar with Tehama County, but
26 what is the population generally?

27 MR. KOENIG: It's 41,000 sir.
28

1 SENATOR MELLO: You keep referring to administrative
2 unit like Los Angeles might refer to a unit here and a unit
3 there.

4 A county which I would call small compared to other
5 larger counties, Tehama County, you would think --

6 MR. KOENIG: Very small.

7 SENATOR MELLO: -- that the Sheriff would know what was
8 going on and was in charge, and not just let some undersheriff
9 or some other lieutenant issue gun permits, which I think are
10 very serious.

11 The reason I follow this line of questioning is because
12 on the Board that you are serving, a lot of people will coming
13 before you with prior arrests and prior backgrounds, and I
14 personally feel there are a lot of people in jail that should
15 never get out. They're just not fit to be on the streets with
16 society. And there's some that could be rehabilitated, and if
17 they are and they've paid their debt to society, then the
18 process allows them to come out under supervision and so forth.

19 But I think carrying guns for people that have committed
20 -- I mean, I support the right to carry a gun. And I and my
21 family have had a gun; never been arrested for a gun in my life.
22 But it's these people who misuse weapons that I think should
23 never be re-licensed to have one. And if they commit a crime
24 with a weapon, I just think they ought to be locked up and not
25 be back on the streets so they can recommit their crime again.

26 MR. KOENIG: I agree with you, Senator.

27 SENATOR MELLO: Thank you.
28

1 CHAIRMAN ROBERTI: Any further questions?

2 There is a motion. Senator Craven moves Mr. Koenig's
3 nomination be recommended to the Floor do pass.

4 Secretary will call the roll.

5 SECRETARY WEBB: Senator Doolittle. Senator Mello.

6 SENATOR MELLO: Aye.

7 SECRETARY WEBB: Senator Petris. Senator Craven.

8 SENATOR CRAVEN: Aye.

9 SECRETARY WEBB: Senator Roberti.

10 CHAIRMAN ROBERTI: Aye.

11 The vote is three to nothing; confirmation is
12 recommended to the Floor.

13 Congratulations.

14 MR. KOENIG: Thank you.

15 (Thereupon this portion of the
16 Senate Rules Committee hearing was
17 terminated at approximately 4:35 P.M.)

18 --oo0oo--
19
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CERTIFICATE OF SHORTHAND REPORTER

I, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Senate Rules Committee hearing was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this

10th day of April, 1986.


EVELYN MIZAK
Shorthand Reporter



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no. 22

**SENATE SYMPOSIUM
ON
UNCOMPENSATED HEALTH CARE
AND
ACCESS FOR THE UNSPONSORED
AND INDIGENT PATIENT**

Ca. 1986
**SPONSORED BY THE
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**June 19 and 20, 1986
STATE CAPITOL
SACRAMENTO, CALIFORNIA**

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Statement of
Barbara Shipnuck
Supervisor, Monterey County
Second Vice President, County Supervisors Association of
California (CSAC)

California State Senate Symposium
on
Uncompensated Health Care and Access for the Un-sponsored and
Indigent Patient

June 19, 1986
Room 4203
State Capitol
Sacramento, California

Counties are responsible, in fact are legally liable for the provision of indigent care, and, as such, provide the safety net for all those who would otherwise go unserved, either as providers or as purchasers of health care. Counties in California provide more uncompensated care than any other entity. In FY 84 Counties spent \$980,000,000 on health care. County hospitals account for 11% of the hospital beds in California, yet they provide 61% of the uncompensated care. Counties recognize and accept this responsibility. All we ask are adequate tools with which to do the job.

Costs cannot continue to be shifted in the name of cost containment from the State to the Counties as was done in the Medically Indigent Adult Transfer of 1982. Nor should they be shifted from the private sector to the Counties, as in the proposed SB 1607 which redefines current law to make counties financially liable for payment of physician services rendered to emergency room patients in non-county hospitals. Such shifts just increase the uncompensated care burden on Counties.

Through cost shifting, and by turning away from the disenfranchised, this nation has failed to deal with the question of fiscal, legal and moral responsibility for health care of the poor. The intergovernmental responsibility is particularly unresolved. We have an indigent health care problem in this country because we have failed to resolve this tough question. Since we have not done so, the courts are beginning to make these decisions for us. Lawsuits against Counties for indigent care are common and the courts' rulings

against Counties are alarming.

We are all well aware of the consequences. Quite simply stated, health care costs are astronomical and the state of our nation's health is unacceptable. Health care is still the most inflationary sector of the economy. In 1983, the cost of medical care rose at a ten percent rate, more than triple the 3.2 percent increase in the overall consumer price index. While we are spending over a billion dollars a day on health care, there are still over 38 million uninsured Americans; we produce the second greatest number of low birth weight babies among western countries; and neonatal intensive care is the single largest portion of uncompensated care costs. There are homeless without health coverage; children not immunized; and elderly increasingly unable to afford health care.

As the governments closest to the people, counties are painfully aware of this growing indigent population and the constraints on resources with which to serve it. The limitations include regulatory policies within the health care delivery system, such as rate setting and prospective payment mechanisms, and competition among providers which excludes those who cannot pay.

The increase in medical indigency combined with the increased emphasis on competition in health care delivery increases the potential for reduced access for this population to hospital care. The links between price competition, prospective pricing and uncompensated care are clear. Competition begins with purchasers trying to attain the most

services for the dollars expended. This has generally taken the form of contracting with providers offering the lowest prices. Traditionally, large purchasers such as Medicare, Medicaid, and, in some cases, Blue Cross, have reimbursed hospitals including County hospitals at rates below full costs. Hospitals have attempted to recoup these payment shortfalls through increased charges to charge-paying payors.

The tremendous cut-backs in 1982 brought forth a sizable new group of indigent disenfranchised patients and resulted in savings to the Medi-Cal program in excess of half a billion dollars annually. By shifting responsibility for the Medically Indigent adults to the Counties with initially inadequate reimbursement which has further declined in real dollars, and restricting benefits and eligibility the State insured that a good portion of these savings came at the expense of the indigent and the hospitals which provide their care.

In competitive health care markets, where buyers are seeking the best price, there are incentives for providers to reduce their costs by eliminating services which are not associated with payment or which require internal subsidization. The price-competitive nature of the hospital industry makes it next to impossible for some hospitals to subsidize uncompensated care from paying patients and other sources. Since some of the costs of the care of the uninsured, underinsured and publicly sponsored patients have traditionally been passed on to other payors by hospitals, competition with adversely affect those institutions that provide care for a high or disproportionate

share of these populations, government, and in California that means County government, will be called on in a competitive system to provide new direct subsidies to replace the hidden ones previously depended upon.

Competitive systems cannot be expected to function in the public interest unless the needs and costs of this population are supported. In fact, the conceptual underpinnings of the "competitive model" in health care assume low income consumers are provided with the means to purchase a competitive health benefit option. Otherwise, private providers will increasingly leave the field, thereby placing an ever increasing burden on Counties. What lies before the State is the conceptually complex task of competition damage control.

From 1982 - 1983 the percent of bad debt and charity care provided by County hospitals rose from \$227 million to \$380 million or from 45 percent of the total uncompensated care provided to 55% percent. From 1983 - 1984 the amount rose by an additional \$180 million and now accounts for 61% of the aggregate bad debts and charity care. Data from 1984 - 1985 leads to the conclusion that many hospitals are continuing to reduce their losses from uncompensated care, and so we should see another rise in the County proportion when figures are finalized.

State policies should not be derived solely from ideas that focus predominately on subsidizing providers for uncompensated care. The costly institutional bias of the Medicare and Medicaid programs should be a lesson to us to orient programs

toward keeping individuals healthy, as opposed to a provider oriented approach. All levels of government should be used to implement programs. An attempt to define indigent care should not overlook the elderly, as Counties and faced with severe shortages in resources for their care. Reforms in the provision of long term care must be a priority, as the drain on health care dollars continues to grow for care provided in the last year of life and the first year of life.

The needs of infants and children must be given greater attention. A dollar spent for adequate pre-natal care saves at least \$1.70 in complicated neo-natal treatment. The battle against measles once thought to be won in this State now appears to need new vigorous action. While we focus on in-patient acute care in discussions of uncompensated care we must recognize that Counties are in a unique position to meet public health objectives which could result in savings of more expensive treatment modes.

County governments have the incentive to provide quality care in a cost effective manner because we are legally and financially liable. As public officials we have proven our support for such programs. Counties are closest to the people being served, and therefore, are in the best position to know the needs of the populations. We can target resources effectively and spot problems before it is too late. Several Counties have attempted to reorganize their health care systems to better provide services and conserve shrinking health care dollars.

Sacramento County has implemented an innovative, readily accessible, but controlled delivery system for a full spectrum of medical care. Primary care clinics are spread geographically in the County and are organized to assure access to basic physician services. All advanced levels of care are available through County case management. The entire program is organized to maximize available resources, expanding on existing County programs where necessary.

Contra Costa County has a prepaid managed health care plan. The County operates a network of health clinics and a County hospital and is a major provider of care to the County's Medicaid (Medi-Cal) and medically indigent populations.

The County began experimenting with prepaid approaches for the Medi-Cal population in the early 1970s. By 1980, the County's prepaid system had become a federally qualified HMO, with a large Medicaid enrollment but relatively few medically indigent individuals. The medically indigent, in general, continued to use the County delivery system on a fee-for-service basis.

During a severe financial crunch in 1982, the State dropped medically indigent adults from the State-funded Medi-Cal program and returned responsibility for them to the Counties, together with block-grant funding approximating 70% of the prior year's expenditures. The Contra Costa Board of Supervisors determined that the County would continue to make services available to this population, but only through enrollment in the prepaid Contra Costa Health Plan, with premiums of \$125-\$135 per member

month paid by the county to the health plan. This decision reflected the Board's view that managed health care in the prepaid plan would be preferable to episodic care sought as needed by the recipients and that, by keeping the recipients healthy, long run costs would be reduced. Short run costs probably would have been fewer for the County if it had merely subsidized the operating losses due to bad debts at the County clinics and hospitals.

In my own County, Monterey, we undertook a pilot project in conjunction with the State Department of Health Services. While this capitated Medi-Cal model was not ultimately successful the lessons learned from its failure also served of value to the State. The cost to the County, which was not the administering agency for the project, will be between \$740,000 and \$1.3 million depending upon the State assuming some of the outstanding liability and the ultimate bankruptcy settlement. This loss is due to the debt owed Natividad Medical Center which, as the County hospital, provided the largest proportion of care to the affected population.

Counties are in a position to effect real changes and savings in the health care delivery system. Partnerships formed between the State and Counties and between the private sector and Counties can shape the system in a way to effect positive results for all, but only if the unique role of Counties is not stretched to the point where the system providing the bulk of the indigent care in this State collapses. Resource limitations, a rising tide of mandates, lawsuits and court

rulings which hold Counties legally liable for indigent care, and a competitive market environment which makes it increasingly difficult for hospitals to balance the conflicting objectives of caring for the poor and their own economic viability, threaten the very survival of our public health system.

An uncompensated care policy for California must define the roles of the State, the Counties and the private sector. It must assure access to needed services for the growing population falling through the cracks and provide relief for those institutions on which the unsponsored poor are dependent. A combination of short-term and long-term actions is required. The plight of disproportionate providers must be addressed immediately, while programs are restructured to insure adequate access for the medically indigent and medically needy. Cost shifting must stop and real solutions put in place. Benefits must be extended to people who are uninsurable, underinsured, unable to provide for their own care, and undocumented immigrants who do not now qualify for Federal and State programs. Only a comprehensive approach, which recognizes shared responsibility will stave off the impending crisis and prevent the collapse of the public health care system as we know it in California.

Some Strategies for Inclusion in a Comprehensive Uncompensated Care Policy for California.

Short term: Those that would have immediate results, particularly upon Counties and Public Hospitals.

1. Anti-dumping legislation.
2. Establishment of a policy which ties tax exempt status or use of tax exempt financing to a requirement for provision of a proportion of uncompensated indigent care.
3. State and Federal recognition of their role and responsibility in providing care for undocumented aliens.

Long term: Policies which are complex to develop and which would have long term results and possible systemic changes.

1. Encouragement of existing and development of new intermediate care modes (e.g., in-home, hospice, free standing psychiatric facilities) with adequate reimbursement mechanisms.
2. Capitalization for public facility improvements.
3. Stimulation of innovative programs with risks and savings shared between the administering agency and the State.
4. Increased emphasis on preventive health initiatives--This falls in both short and long term categories.

STATE OF CALIFORNIA
SENATE SYMPOSIUM ON UNCOMPENSATED CARE

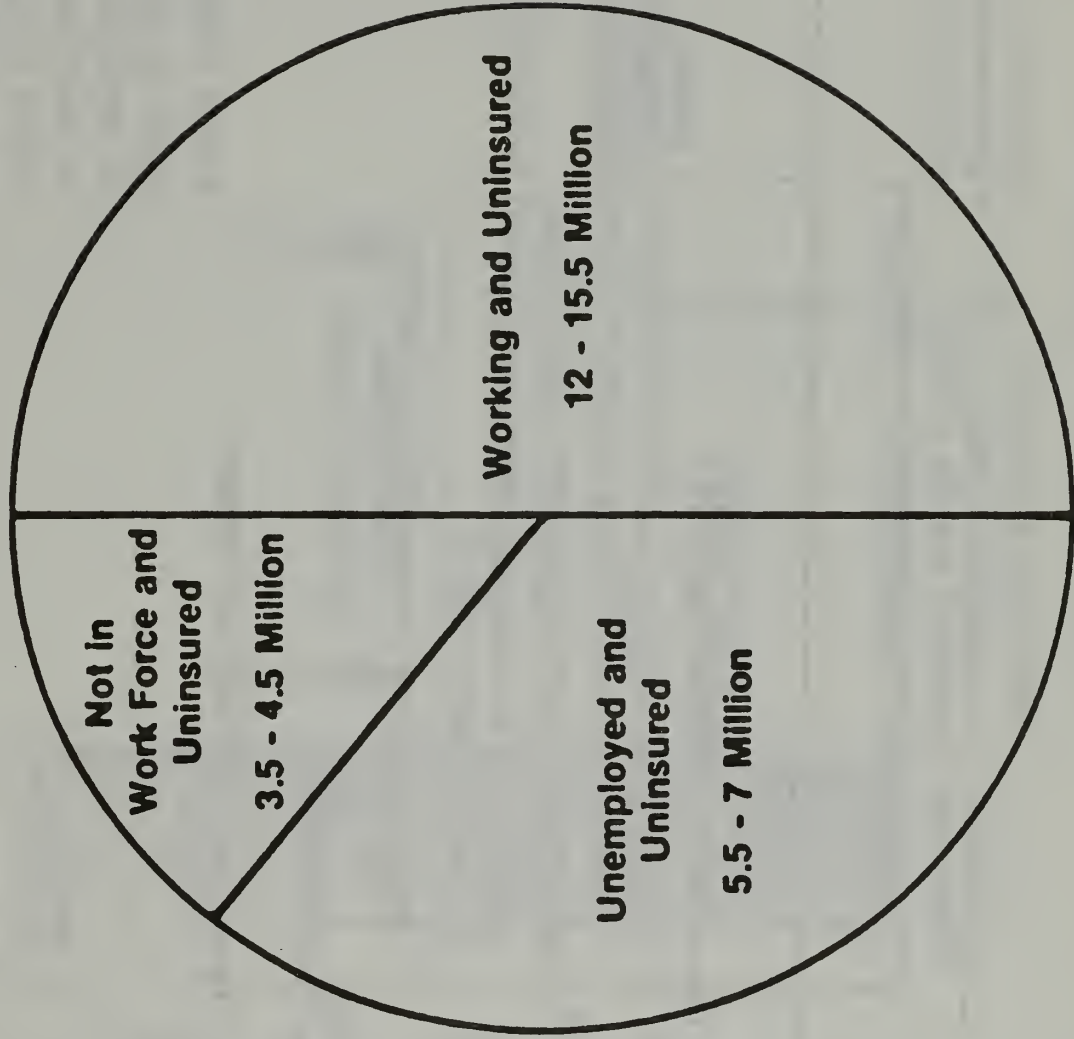
MATERIALS PREPARED
BY
ROBERT DERZON
VICE PRESIDENT

JUNE 19, 1986

WHO ARE THE UNINSURED?

THE UNINSURED - 1983

Total = 21 - 27 Million

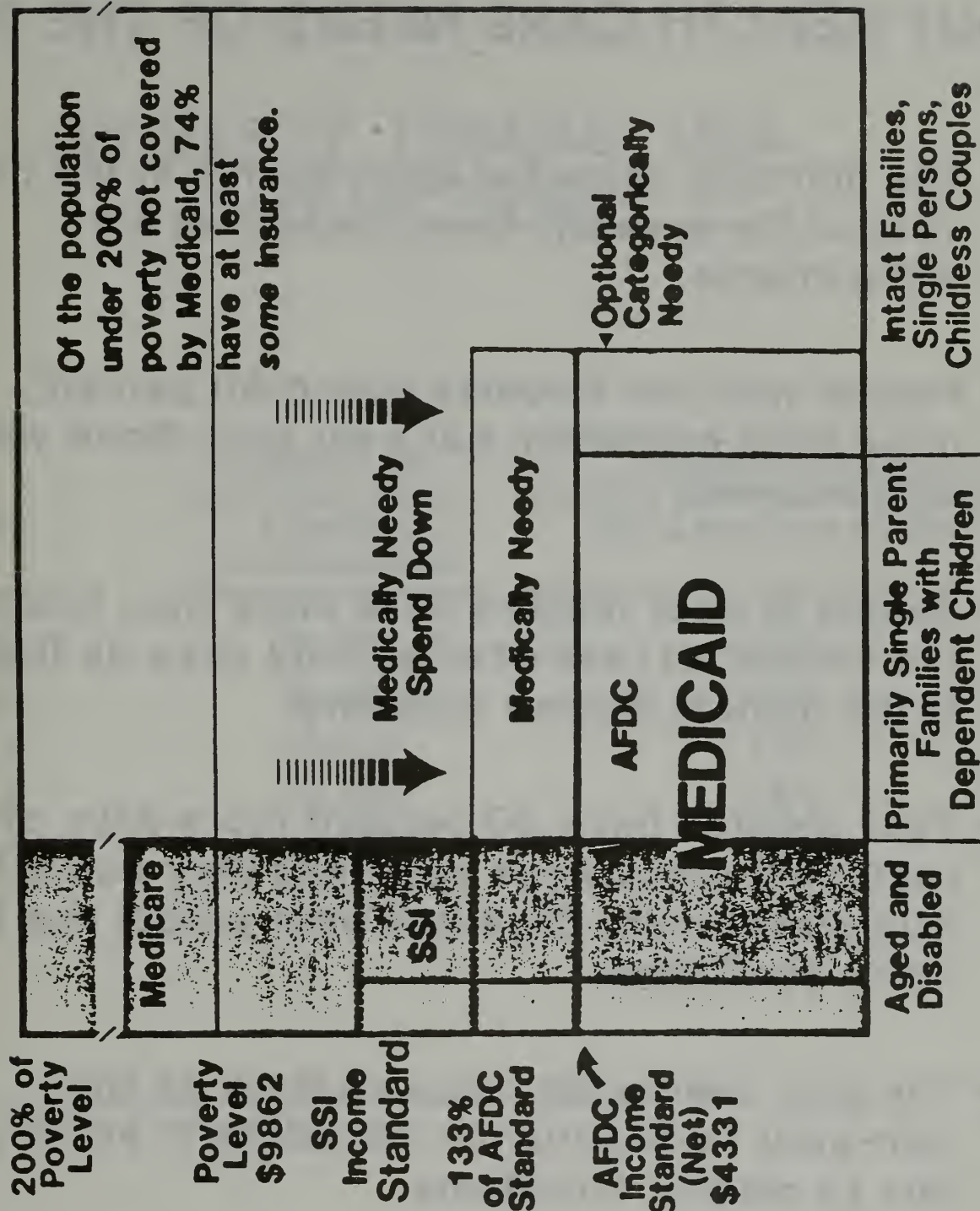


Source: Robert J. Blendon, et. al. "Health Insurance for the Unemployed and Uninsured." National Journal, May 28, 1983.

WHO ARE THE MEDICALLY INDIGENT?

- **The uninsured poor/near poor**
 - Persons below Medicaid income cutoffs but still not eligible (e.g. intact families, childless couples, or single individuals).
 - Persons who are "categorically" eligible (largely single-parent families, aged, blind, and disabled) for Medicaid but not financially eligible.
 - Other low-income persons without insurance.
- **The underinsured.**
- **The non-poor with high cost illnesses.**

WHO ARE THE INSURED AND UNINSURED POOR?



Categories of People

WHAT NATIONAL STUDIES SHOW ABOUT HEALTH CARE NEEDS OF THE POOR

- **The mortality rates for black infants in the first year of life is nearly twice as high as for white infants.**
- **People with low incomes spend 60 percent more days bedridden per year than those with high incomes.**
- **People in poor families have more than twice the number of restricted activity days as those in the highest income category.**
- **Poor children have 30 percent more days of restricted activity per year than their peers and 40 percent more days lost from school due to acute conditions.**
- **The poor are nearly twice as likely as the non-poor to experience limitations in activity due to chronic conditions.**

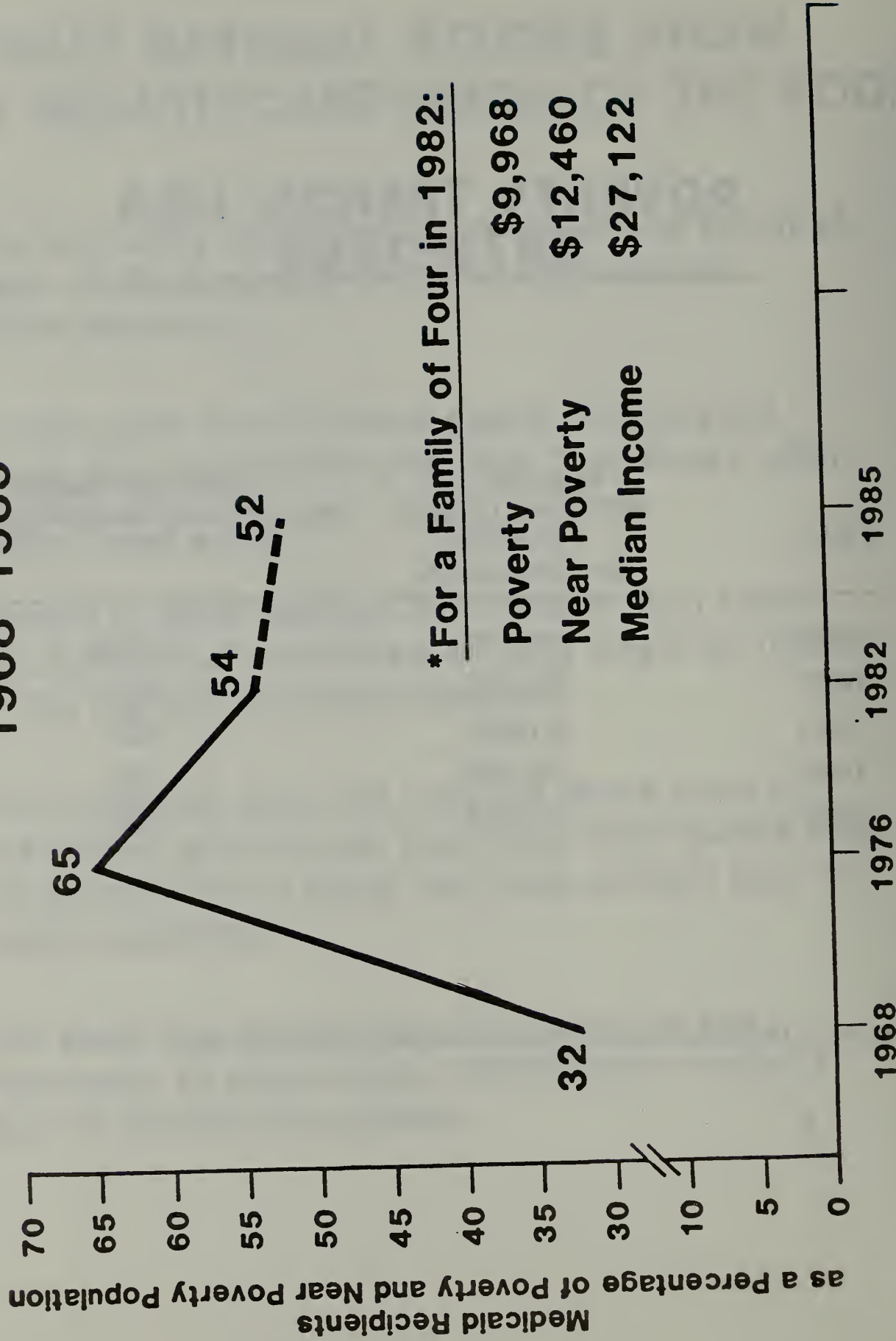
POVERTY TRENDS: USA 1979-1983

YEAR	NUMBER OF PERSONS UNDER POVERTY (in thousands)	PERSONS UNDER POVERTY AS A PERCENTAGE OF U.S. POPULATION
1979	26,072	11.7%
1980	29,272	13.0
1981	31,822	14.0
1982	34,398	15.0
1983	35,266	15.2

SOURCE: U.S. Census Bureau, Phone Conversation, August 20, 1984

MEDICAID RECIPIENTS AS A PERCENTAGE OF THE POVERTY AND NEAR POVERTY POPULATION*

1968-1985



Source: Robert J. Blendon, et. al. "Health Insurance for the Unemployed and Uninsured." National Journal May 28, 1983. (Note: "Medicaid Recipients" is the number of people who used at least one Medicaid service during the year and is not the same as the number of persons

FEDERAL HEALTH BLOCK GRANTS TO THE STATES

FY 1981 to FY 1984

(In Millions)

Grant	FY1981*	FY1982	FY1983	FY1984	Percent Change, 1981-1984, Adjusted ** for Inflation **
Maternal and Child Health	\$451	\$374	\$478	\$399	-24.5%
Preventive Health Services	99	82	85	87	-25.0%
Alcohol, Drug Abuse, and Mental Health Services	541	428	468	462	-27.1%
Primary Care *** (as proposed for FY1985)	533	446	525	522	-16.4%

* FY 1981 was prior to block grant implementation. This column displays the total amount of the categorical grants that were later subsumed under the block grants.

** Based on change in the CPI index between January 1981 and January 1984.

*** This block grant has been proposed by the president for FY 1985 to include funding for Community Health Centers, the Black Lung Program, the Migrant Health Program, and Family Planning. Shown here are the totals for each of these four categorical programs, as funded between FY1981 and FY1984.

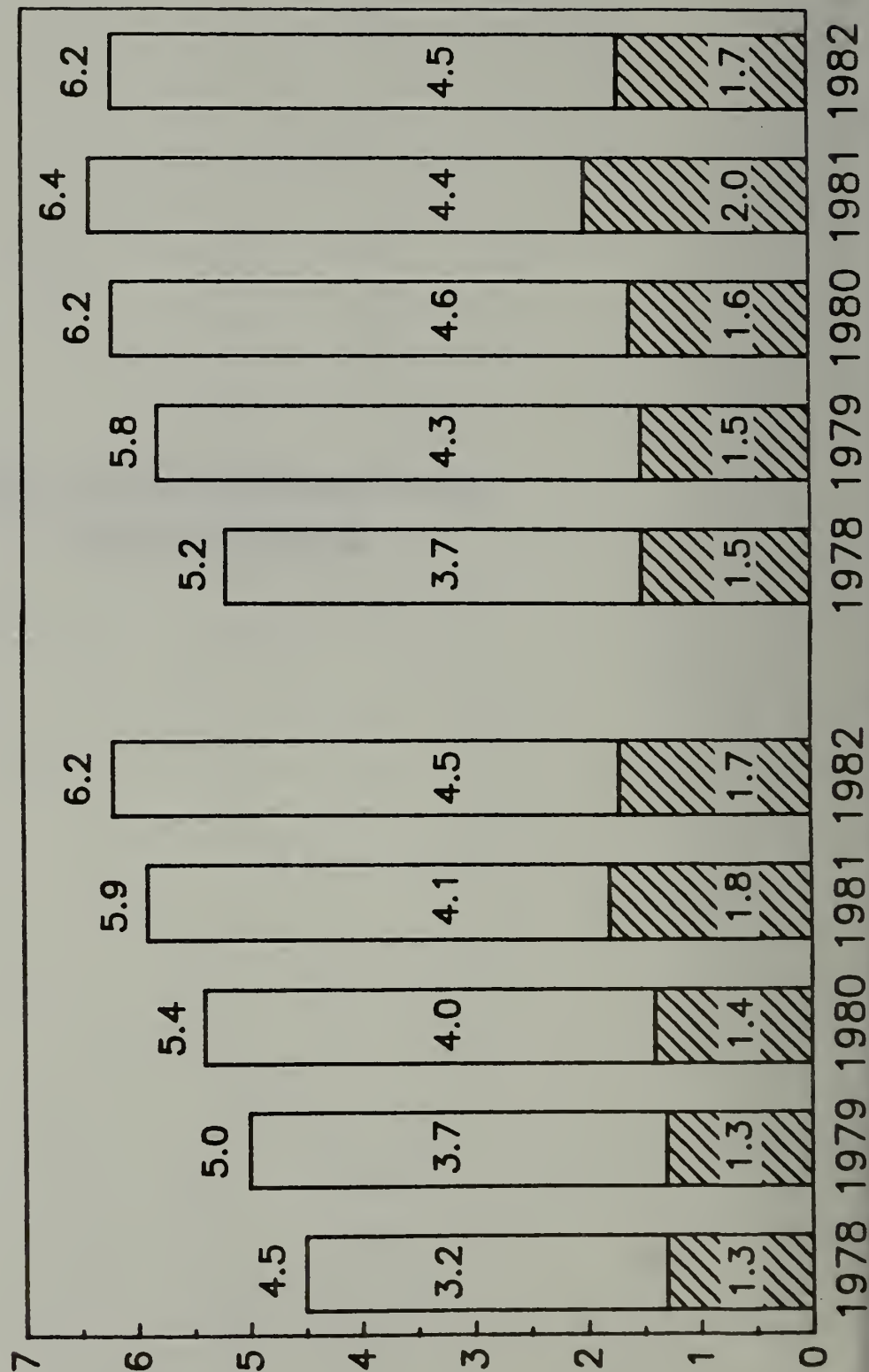
Source: Calculated from data in: Jeffery C. Merrill and Karen W. Tyson. The President's 1985 Budget: An Analysis (Center for Health Policy Studies, 1984).

HOW MUCH UNCOMPENSATED CARE IS THERE?

WHO BEARS THE BURDEN?

VOLUME OF UNCOMPENSATED CARE - (Billions of 1982\$)

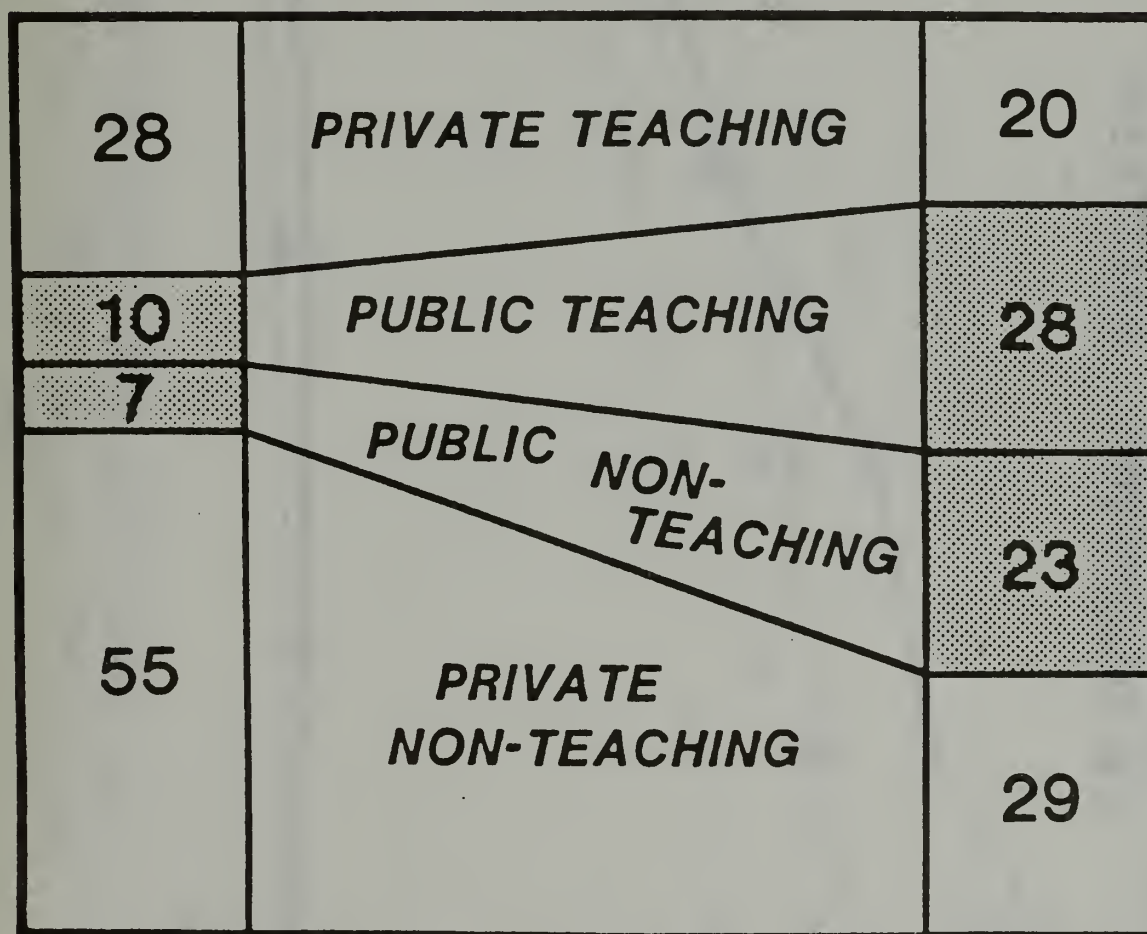
Charity Care  Bad Debt 



SHARE OF UNCOMPENSATED CARE: 100 LARGEST CITIES (Adjusted Patient Days) 1982

Percent of
Total Volume
of Care

Percent of Total
Uncompensated
Care

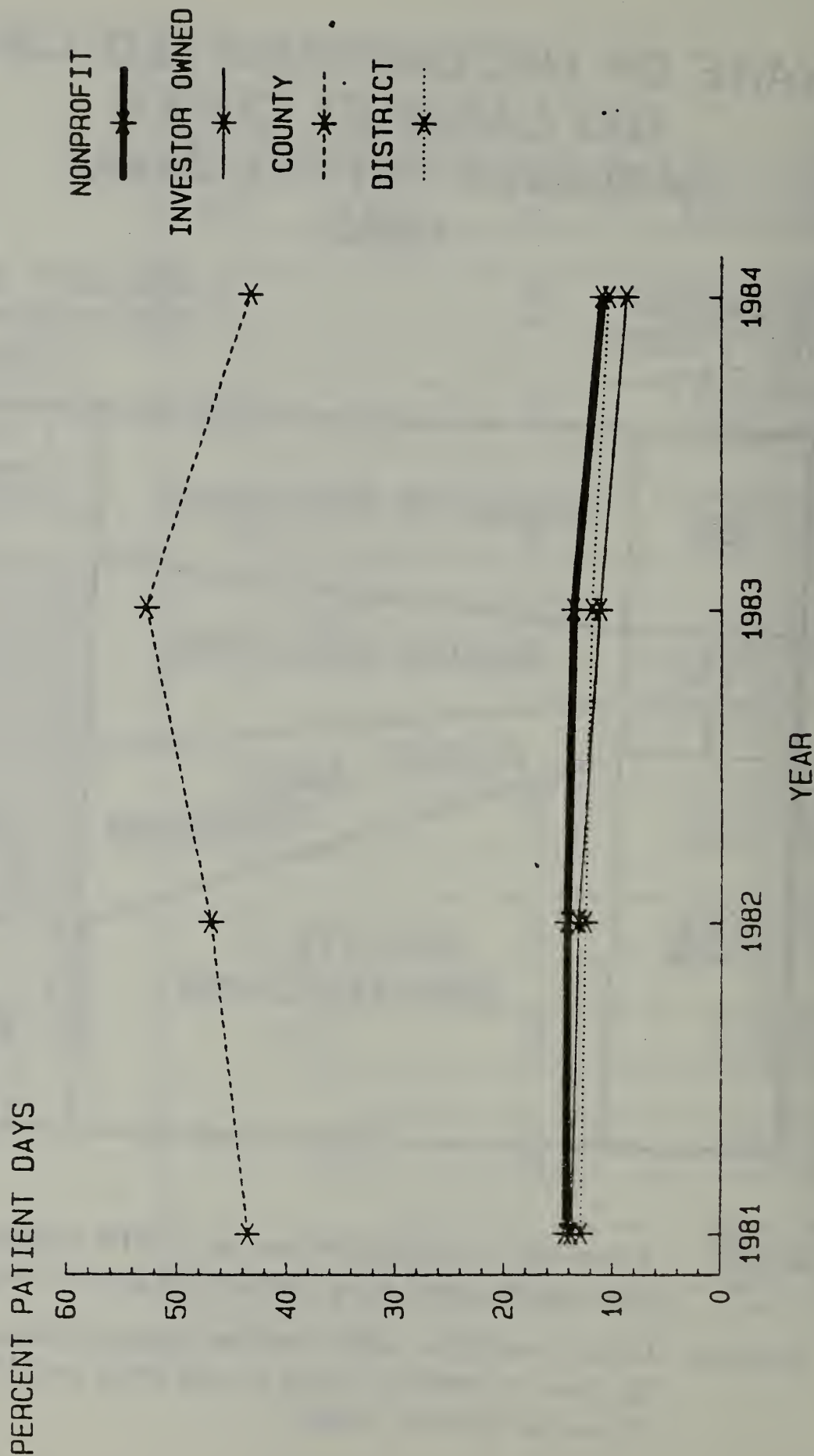


Notes: Teaching hospitals defined as COTH member hospitals.
Uncompensated care defined as charity and bad debt.

Source: Urban Institute and American Hospital Association,
"Survey of Medical Care to the Poor and Hospitals'
Financial Status, 1982".

"DRAFT DOCUMENT
(No Slide)"

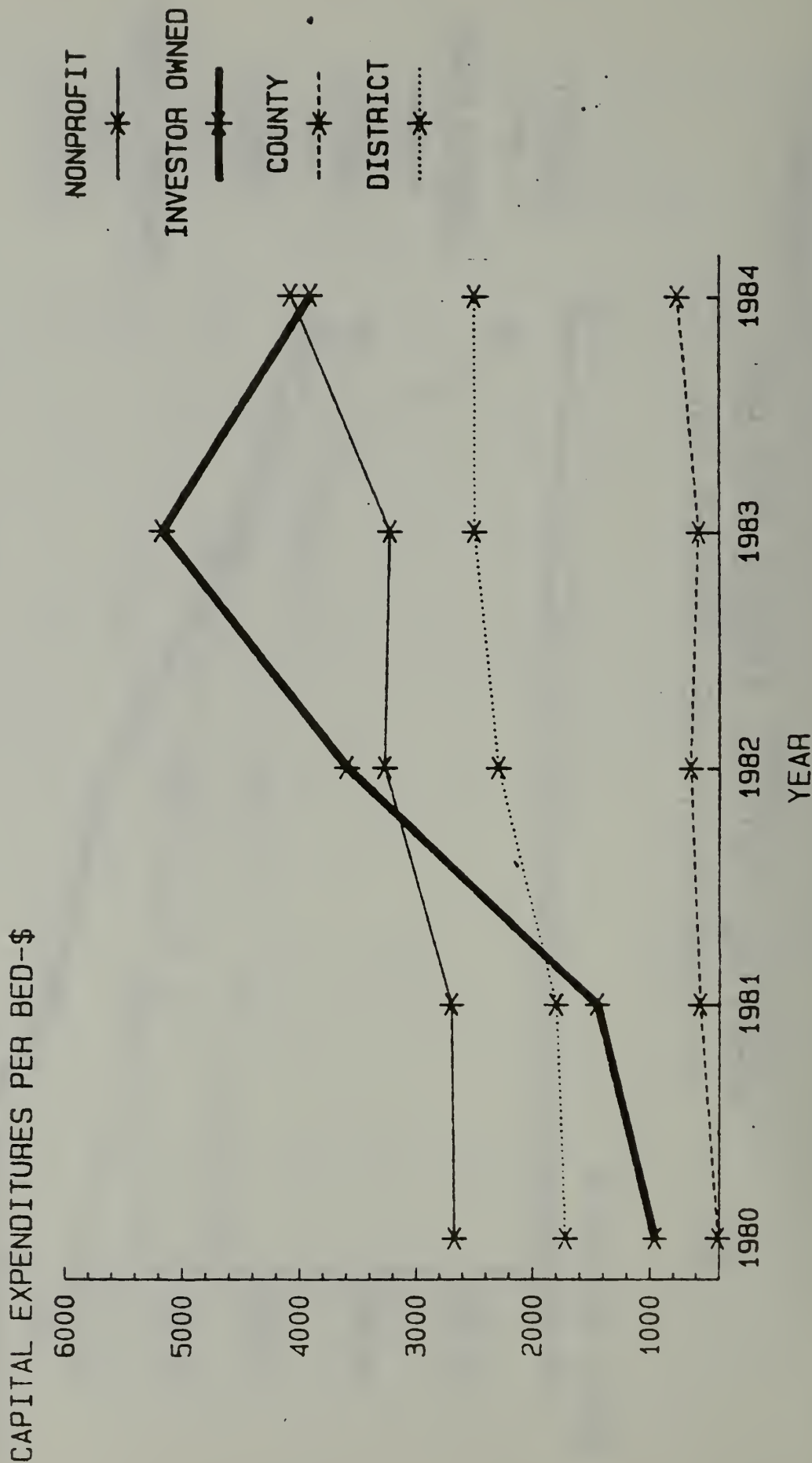
PERCENT HOSPITAL MEDI-CAL PATIENT DAYS BY OWNERSHIP - STATEWIDE



HOSPITAL CAPITAL ASSETS PER BED BY OWNERSHIP LOS ANGELES HSA



HOSPITAL CAPITAL EXPENDITURES PER BED BY OWNERSHIP



(NO SLIDE)

ESTIMATED COST OF HOSPITAL BAD DEBT
AND CHARITY CARE PER PATIENT DAY
1980-81

COUNTY HOSPITALS	\$115
NON-PROFIT HOSPITALS:	
CHARITABLE (RELIGIOUS)	11
OTHER	16
INVESTOR-OWNED HOSPITALS	12
DISTRICT HOSPITALS	12

SOURCE: CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS
WHITE PAPER ON THE UNIQUE CONTRIBUTIONS
AND NEEDS OF CALIFORNIA'S PUBLIC HOSPITALS

(No SLIDE)

AGGREGATE UNCOMPENSATED CARE COSTS
(MILLIONS)

	BAD DEBTS AND CHARITY	UNREIMBURSED MEDI-CAL	TOTAL
1981	\$493.6	\$466.9	\$960.5
1982	506.5	624.2	1,130.7
1983	688.3	717.9	1,406.2

SOURCE: CALIFORNIA HEALTH FACILITIES COMMISSION
AGGREGATE DATA, COVERING HOSPITAL FISCAL YEARS
ENDING JUNE 29, 1982 THROUGH JUNE 29, 1984.

The following table projects data using 1983 and 1984 quarterly data on total deductions from revenue. Bad debts and charity care were estimated using the proportion of deductions historically represented by these categories. As in the annual data, county hospitals lead the field, non-profits are next, investor-owned next, and districts last. The 1983-84 annual data, when available, may show an even greater concentration in county facilities.

PROJECTED COST OF BAD DEBT AND CHARITY CARE BASED ON
QUARTERLY DATA
(Dollars in Millions)

	CY 1983		CY 1984	
County/City	\$377.9	48.3%	\$476.5	51.8%
Non-Profit	307.4	39.3%	333.7	36.3%
Investor-Owned	63.7	8.1%	72.9	7.9%
District	22.7	4.2%	36.6	4.0%
TOTALS	\$781.7		\$919.7	

Source: CHFC Quarterly Data

The distribution of licensed beds, in relation to the proportion of uncompensated care provided by each of the hospital types, based on the projected data, reflects a much larger contribution by public hospitals. County/City hospitals provide over half of the uncompensated care with only a little over 10% of the licensed beds.

	County/ City	Non- Profit	Investor- Owned	District
Percentage of Available Beds	11.5%	56.2%	23.9%	8.4%
Percentage of Bad Debt and Charity Care	51.8%	36.3%	7.9%	4.0%
Ratio	450.4%	64.6%	33.1%	47.6%

The California Association of Public Hospitals (CAPH) has concluded that the existence of a "safety net" of public and private indigent care providers seems to provide tangible

WHAT ARE STATES DOING ABOUT
THE PROBLEM OF INDIGENT CARE?

SPECIAL STATE TASK FORCES 1983-1985

23 STATES

Arkansas	Ohio
Colorado	Oklahoma
Florida	Oregon
Georgia	South Carolina
Indiana	South Dakota
Kentucky	Tennessee
Maryland	Utah
Massachusetts	Virginia
New Hampshire	Washington
Nebraska	West Virginia
New Mexico	Wisconsin
North Carolina	

SUGGESTED STATE POLICY OBJECTIVES

- **Target Funds for the Neediest**
- **Stimulate Effective Patient Care Systems**
- **Retain Incentives for Private Insurance**
- **Level the Provider Playing Field**
- **Maximize Federal Payments**
- **Monitor Indigent Care Periodically**
- **Assure Tax Exemption to Charitable Institutions**

NINE STATE POLICY APPROACHES TO INDIGENT CARE AND FINANCING

- **Medicaid Enhancement**
- **Direct Institutional Support**
- **Assistance to Special Patient Groups**
- **Use of State Regulation**
- **Insurance/Indigent Care Pools**
- **All-Payer Systems**
- **Catrapstrophic Insurance**
- **Private Insurance Expansion**
- **State Aid to Counties**

"Prepared for the Colorado Task
Force on the Medically Indigent,
January, 1984"

Appendix 1

OPTIONS FOR FINANCING HEALTH CARE
FOR THE UNINSURED AND UNDERINSURED

OPTIONS FOR FINANCING HEALTH CARE FOR THE UNINSURED AND UNDERINSURED

STATE OR LOCAL PROGRAMS TO PAY FOR SERVICES

	STATE/COUNTY MEDICAL INDIGENCY	SPECIFIC CONDITION PROGRAMS	CATASTROPHIC EXPENSE PROGRAM	SUBSIDIZATION OF SERVICES
Description of Approach	State or local governments provide funds for care of at least some indigents unable to pay for their own care. (See Appendix 2 for detailed examples).	State or local government provides funds for care of individuals with specific conditions and without third party or personal resources to pay for care. State programs that pay for neonatal intensive care are an example.	State serves as payer of last resort for state residents who have exhausted insurance benefits (if any) and have substantial out-of-pocket expenses for medical care as a proportion of family income. Levels of out-of-pocket expenses are defined to be high enough to provide incentive for having health insurance, if possible.	State or local government provides operating subsidies to: • Public hospitals • Public clinics • Private hospitals • Private clinics to underwrite costs of uncompensated care for the poor & uninsured.
Who is Served by This Program?	<u>POOR AND NEAR-POOR WITH HIGH EXPENSES</u> • Covered population varies widely from state to state. Some states cover only general assistance, others cover broader groups. • Not usually an entitlement program; total population covered is often limited by level of appropriation	<u>POOR & NEAR-POOR WITH SPECIFIC HIGH EXPENSE CONDITIONS</u> • Payment is only for specific services. • Eligibility is means tested.	<u>PERSONS EXPERIENCING HIGH EXPENSE ILLNESS</u> • Uninsured and underinsured. • Eligibility based on out-of-pocket expenses for medical care and family income. • One goal is to prevent families from becoming impoverished by high medical bills. • Out-of-pocket costs set high enough to maintain incentive to have insurance coverage if possible. • Relatively small number, reflecting low incidence of catastrophic expense and high levels of public and private coverage.	<u>POOR AND NEAR-POOR IN SERVICE AREA</u> • Primary recipients will be those in service area. • Some poor and near-poor receiving services in other settings may be shifted to public settings by private providers. • Access is limited by budget-imposed constraints on staff, facilities, and hours.
What Choices in Benefits?	<u>SPECIFIED SERVICES</u> • May cover hospital, physician or other care. Some programs provide some services as state Medicaid program; others much less. • Substantial discretion often permitted.	<u>SPECIFIED CONDITIONS AND TREATMENTS</u> • States most frequently provide neonatal intensive care; crippled children; shock, trauma, and burn. • In some states, programs for other conditions, such as cancer, have been proposed.	<u>BROAD RANGE OF SERVICES</u> • All programs cover hospital, medical and surgical care. • Key issue is deductibles and copayment levels, which vary: -- Alaska deductible combines fixed payments and percentages of family income. -- Maine and Minnesota deductible based on percent of family income, Minnesota has 10% copayment. -- Rhode Island deductibles based on quality of insurance. • Another issue is whether to base coverage on family outlays or expenses incurred above insurance, regardless of whether paid. • Inclusion or exclusion of mental health or institutional long term care can have major consequences for program costs.	<u>OFFERED SERVICES</u> • Services limited to those offered by subsidized providers. • If hospital, especially teaching hospital with outpatient clinics, services may be extensive. • Mental health and long term care services may be provided by state and local government facilities.

STATE OR LOCAL PROGRAMS TO PAY FOR SERVICES (CONT.)

	STATE/COUNTY MEDICAL INDIGENCY		SPECIFIC CONDITION PROGRAMS		CATASTROPHIC EXPENSE PROGRAM		SUBSIDIZATION OF SERVICES	
	STATE AND LOCAL APPROPRIATIONS		STATE, LOCAL AND FEDERAL APPROPRIATIONS		STATE APPROPRIATIONS		STATE AND LOCAL APPROPRIATIONS	
How Can the Program be Financed?	<ul style="list-style-type: none"> Programs funded through general revenues. May be funded by state, by locality, or by both. 		<ul style="list-style-type: none"> Programs funded through general revenues. Federal funds, such as Title V Maternal and Child Health or Crippled Children (now part of MCH Block Grant) may be used. 		<ul style="list-style-type: none"> All programs funded through general revenues. Maine supplements with cigarette tax. 		<ul style="list-style-type: none"> Subsidies provided through state & local general revenues. The number of federal programs to provide these services (e.g., community health centers) is stable or declining. Charges can be made to third party payers, where available. Service recipients appear less inclined to provide insurance data. 	
How Can Program Costs be Controlled?	<p><u>BENEFITS, ELIGIBILITY AND REIMBURSEMENT</u></p> <ul style="list-style-type: none"> Substantial control may be exercised over the types of services paid for and means test for program eligibility. Reimbursement may be at less than costs. Program expenses can be controlled through budget and appropriations process for programs not offered as an entitlement. 		<p><u>APPROPRIATIONS AND ELIGIBILITY</u></p> <ul style="list-style-type: none"> Lump sum payments may be made to providers who then screen for eligibility. Eligibility means tests may be changed. Not an entitlement; enrollments can be controlled and limited by available funds. Can be expensive if disease has high incidence & eligibility is generous. 		<p><u>BENEFIT AND ELIGIBILITY</u></p> <ul style="list-style-type: none"> State maintains control over financing and administration. State program costs grew rapidly as program established. State responses have been to restrict eligibility, increase deductibles, and copayments, and change benefits. 		<p><u>APPROPRIATION</u></p> <ul style="list-style-type: none"> Appropriation process determines degree of spending and therefore scope of services provided. Costs of subsidizing large hospital can become very extensive. 	
How Can the Program be Administered?	<p><u>STATE/COUNTY SOCIAL SERVICE DEPARTMENTS</u></p> <ul style="list-style-type: none"> Overall administration by social services or health agency. Eligibility determination usually done by case workers. 		<p><u>SOCIAL SERVICE DEPARTMENTS OR CONTRACT PROVIDERS</u></p> <ul style="list-style-type: none"> Eligibility determinations may be made by social service case workers or provider admission personnel if lump sum payment is provided to institution. 		<p><u>STATE AGENCIES/INSURERS</u></p> <ul style="list-style-type: none"> Overall administration assigned to existing state social services or health agency, for their private contractors which often use existing personnel. Eligibility determinations usually done by social service case workers. Use of existing agencies and personnel have created some staffing shortages but probably kept administrative costs low. 		<p><u>STATE OR LOCAL AGENCY</u></p> <ul style="list-style-type: none"> Legislative appropriations may go directly to providers or be administered by Department of Health and Budget Office. State or local health departments may run health care facilities or clinics. 	
What Legal or Political Issues are Involved in This Approach?	<ul style="list-style-type: none"> These programs may serve as partial state or locally funded substitute for Medicaid medically needy program. Conflict between state and local governments over responsibility. 		<ul style="list-style-type: none"> May generate pressures for creation of similar program for other conditions. 		<ul style="list-style-type: none"> To some extent, in states with no Medicaid medically needy program, the program serves as state funded substitute. Program has not been challenged in court. 		<ul style="list-style-type: none"> Delivery of health care services requires state or locality to commit substantial managerial and financial resources. Subsidized providers can become strong lobbyists for maintaining or expanding subsidies. 	

MIXED PUBLIC/PRIVATE APPROACHES

	STATE RISK-SHARING POOLS	MANDATED EMPLOYER-BASED INSURANCE	INSURANCE REGULATION	PURCHASE OF PREPAID HEALTH PLANS
Description of Approach	<p>Health insurers in the state are required to participate in pool arrangements to make comprehensive insurance available to high risk persons who cannot obtain coverage from other sources. To keep coverage affordable, premiums are capped and underwriting losses are covered by assessments on carriers or state subsidy.</p>	<p>State requires all employers or employers above a certain size to provide health insurance and specifies minimum benefits the insurance must provide. State may provide subsidies to marginal employers unable to afford insurance. Example: Hawaii</p>	<p>State introduces regulations to improve benefit packages or ease state-specific access problems, such as:</p> <ul style="list-style-type: none"> Provisions prohibiting discrimination against handicapped. Provisions to improve group-to-individual conversion policies of laid-off workers. Minimum benefit requirements for employer-based insurance. 	<ul style="list-style-type: none"> State or locality purchases private insurance or prepaid health plan on behalf of the medically indigent. Recipients choose between prepaid plans and pay particular premiums based on income. Example: Multnomah County, Oregon.
Who is Served by This Program?	<p><u>UNINSURED HIGH RISKS</u></p> <ul style="list-style-type: none"> Eligibility may be restricted by regulation or in practice to those who cannot obtain regular coverage. Only those who can afford to buy insurance will participate. State might provide partial premium subsidy for low income, but none have. 	<p><u>VIRTUALLY ALL EMPLOYERS AND EMPLOYEES</u></p> <ul style="list-style-type: none"> Expands insurance to employed currently without insurance (approximately 10 percent). Improves coverage for employees with less comprehensive health insurance. 	<p><u>UNINSURED</u></p> <ul style="list-style-type: none"> This approach expands availability of insurance for moderate risks who have limited access to insurance because of marketing constraints. Can also be used to improve coverage for those already insured. Can also be used to cover laid-off workers or to open enrollment for laid-off spouses of employees. 	<p><u>LOW-INCOME UNINSURED</u></p> <ul style="list-style-type: none"> Multnomah County program serves Medically Needy population and low-income, uninsured persons not eligible for federally supported aid.
What Choices in Benefits?	<p><u>SPECIFIED COMPREHENSIVE BENEFITS</u></p> <ul style="list-style-type: none"> Benefits designed to provide protection against catastrophic expenses, but most plans have also provided comprehensive benefit package. Range of deductibles is usually available. Mental health and long term care usually provided with limited coverage. 	<p><u>SPECIFIED COMPREHENSIVE BENEFITS</u></p> <ul style="list-style-type: none"> Hawaii specifies minimum covered services, deductibles and coinsurance. Mental health and long term care usually provided with limited coverage. 	<p><u>INSURER-DETERMINED OR BY REGULATION</u></p> <ul style="list-style-type: none"> Regulatory changes on access to insurance will not affect benefits. Minimum benefit requirements would specify "qualified" plan. Some states (e.g., New Jersey) have required Blue Cross to offer comprehensive individual conversion policy. 	<p><u>VARYING BENEFITS</u></p> <ul style="list-style-type: none"> Different prepaid health care plans or providers offer varying benefit packages. Recipients choose between plans and pay partial premiums adjusted for the extensiveness of benefits.
How Can the Program be Financed?	<p><u>PREMIUMS</u></p> <ul style="list-style-type: none"> All pools have ceilings on premium levels. Carriers must pay assessments if claims exceed revenues. Minnesota provides public subsidy of risk-sharing pool. 	<p><u>PREMIUMS AND SUBSIDIES</u></p> <ul style="list-style-type: none"> Employers and employees share in the cost of premiums. Hawaii limits the employees' share of premiums and subsidizes small employers who cannot afford premiums. There have been few requests for supplementation. 	<p><u>PREMIUMS</u></p> <ul style="list-style-type: none"> Insureds would pay for policies. In New Jersey case, Blue Cross subsidized conversion policy from other lines of business, with plan claiming it affected its competitive position. 	<p><u>PREMIUMS: GOVERNMENT FUNDS</u></p> <ul style="list-style-type: none"> Multnomah County combines federal and state Medicaid dollars with County revenues and subscriber partial premiums. Medicaid funds provided under special waiver allowing prepaid approach.

	STATE RISK-SHARING POOLS	MANAGED EMPLOYER-BASED INSURANCE	INSURANCE REGULATION	PURCHASE OF PREPAID HEALTH PLANS
	ELIGIBILITY AND ADMINISTRATIVE COSTS	STANDARD INSURANCE COST CONTROLS	STANDARD INSURANCE COST CONTROLS	PROSPECTIVE PAYMENT
How Can Program Costs be Controlled?	<ul style="list-style-type: none"> • Preexisting condition restrictions are a major vehicle for controlling the ratio of outlays to premiums. • If premiums are capped, pools with only high risk individuals will more likely need to be subsidized by assessments than pools with more diverse populations. • If assessments can be distributed across a broader number of insurers (particularly self-insured groups), the financial burden for each carrier will be reduced. Assessments on self-insurers have been contested in the courts. • Administrative costs have been higher than expected, in part because of small number of enrollees. 	<ul style="list-style-type: none"> • Costs are borne by insured groups. Utilization and claims review may help control costs. 	<ul style="list-style-type: none"> • Costs are borne by insured groups. Benefit choices and utilization and claims review may provide catastrophic protection and moderate out-of-pocket expenses while keeping premiums low. • Mandating benefits will add expense to insurance. 	<ul style="list-style-type: none"> • Health plans are required to supply comprehensive services for predetermined payment, rather than on fee-for-service basis. • Excessive enrollments of high risk clients in most expensive plans can be discouraged through higher premiums.
How Can the Program be Administered?	<p><u>PRIVATE INSURERS</u></p> <ul style="list-style-type: none"> • Administrative carrier can be selected by participating carriers or by bidding. • All carriers/agents may be authorized to submit applications for coverage. • Multiple pools may be established, as in Connecticut, where Blues were concerned with having major liability with no control. 	<p><u>STATE AGENCY</u></p> <ul style="list-style-type: none"> • Insurance Commissioner, Department of Labor, or Department of Taxation and Revenue may oversee employer compliance. 	<p><u>INSURANCE COMMISSIONER</u></p> <ul style="list-style-type: none"> • Insurance Commission may oversee compliance. 	<p><u>STATE/COUNTY AGENCIES</u></p> <ul style="list-style-type: none"> • Overall administration by agency at state or local level. • Counselors meet with eligibles to explain program and describe variety in availability of plan.
What Legal or Political Issues are Involved in This Approach?	<ul style="list-style-type: none"> • ERISA: Legal suits have challenged state authority to make assessments on self-insurers & payments by those groups in Connecticut and Minnesota have ceased. This creates additional incentives for self insurance, further reducing base on which assessments can be made. • Subsidies: Some carriers have pressed state to subsidize underwriting losses of pool. 	<ul style="list-style-type: none"> • ERISA: There are legal decisions that ERISA preempts state laws mandating coverage. Hawaii has state-specific exemptions to ERISA. • Concern will be raised about ability of business to bear additional costs. • Provides a small additional incentive for employers to self-insure. 	<ul style="list-style-type: none"> • Financial burden of provisions to require employer payments for insurance to laid-off workers may create opposition. • ERISA: ERISA may preempt minimum benefit regulations with regard to self-insurers. 	<ul style="list-style-type: none"> • State needs Medicaid waiver to include Medicaid populations.

MIXED PUBLIC/PRIVATE APPROACHES (CONT.)

	INCLUSION OF FREE CARE/BAD DEBT COSTS IN PROVIDER RATES	CHARITABLE CONTRIBUTIONS	
Description of Approach	<ul style="list-style-type: none"> Hospital free care and had debt subsidized through: <ul style="list-style-type: none"> Hospital charges to self-pay patients, private insurers, and charge-based Blue Cross plans. Allowance for uncompensated care in some cost-reimbursing Blue Cross plans. State rate setting plans that require some or all payers to include allowance for uncompensated care. 	<p>Philanthropic contributions to hospitals help subsidize free care and bad debt; or physicians and other health professionals donate services.</p>	
Who is Served by This Program?	<p><u>UNINSURED AND UNDERINSURED AND OTHERS</u></p> <ul style="list-style-type: none"> Recipients of hospital free care and those unable or unwilling to pay hospital bills. Payments help hospitals with uncompensated care. 	<p><u>POOR AND NEAR-POOR IN SERVICE AREA</u></p> <ul style="list-style-type: none"> Primary recipients will be those in service areas. Private institutions or physicians make decisions on eligibility and access. 	
What Choices in Benefits?	<p><u>OFFERED SERVICES</u></p> <ul style="list-style-type: none"> Whatever services are offered by a particular provider. Mechanisms do not generally influence hospital offering. 	<p><u>PROVIDER-SPECIFIED SERVICES</u></p> <ul style="list-style-type: none"> Available services determined by providers. Hill-Burton obligations can provide minimum level of hospital services in community, but may not match need, and are expiring over time. 	
How Can the Program be Financed?	<p><u>THIRD PARTY PAYERS; SELF-PAY PATIENTS</u></p> <ul style="list-style-type: none"> Charges to self-pay patients, private insurers, and charge-based Blue Cross plans help subsidize uncompensated care. Some cost-reimbursing Blue Cross plans help subsidize uncompensated care. State rate setting programs with uncompensated care allowance spreads costs across most or all payers. 	<p><u>CONTRIBUTIONS AND PATIENT CHARGES</u></p> <ul style="list-style-type: none"> Charitable contributions are made to hospitals; often used to help subsidize free care and bad debt. Physicians or other health professionals donate care. 	

MIXED PUBLIC/PRIVATE APPROACHES (CONT.)

	INCLUSION OF FREE CARE/BAD DEBT COSTS IN PROVIDER RATES	CHARITABLE CONTRIBUTIONS	
How Can Program Costs be Controlled?	<u>RATE SETTING; PROSPECTIVE PAYMENT</u> <ul style="list-style-type: none"> • Rate setting plans are designed to control costs by paying providers at predetermined rate per case or a maximum yearly amount. • Cost-shifting to private insurance and self-pay patients reduced; uncompensated care burden spread among broader base of payers. 	<ul style="list-style-type: none"> • Hospital spending levels determined by extent of Hill-Burton obligations and institutional policy. 	
How Can the Program be Administered?	<u>STATE AGENCY OR COMMISSION</u> <ul style="list-style-type: none"> • In case of state rate setting, state agency or rate setting commission establishes and adjusts yearly rates. 	<u>PRIVATE PROVIDERS</u> <ul style="list-style-type: none"> • Federal government is supposed to monitor Hill-Burton compliance but local government or public groups may monitor independently. 	
Which Legal or Political Issues are Involved in This Approach?	In cases of rate setting with allowance: <ul style="list-style-type: none"> • Medicare and Medicaid require special waivers; special conditions attached to Medicare participation in New York and Massachusetts Plans. • Agreements among insurers and providers often difficult to reach. 	<ul style="list-style-type: none"> • Level of philanthropy and types of services provided may not match community needs. 	

Sources: Jack Needleman, Maren Anderson, and Ross Jaffe. State Options for Addressing Catastrophic Health Expense. (Prepared for the National Center for Health Services Research, U.S. Department of Health and Human Services, by Lewin and Associates, 1983). Jurgovan and Blair, Inc. Evaluation of the Project Health Medically Needy Demonstration (prepared for the Adult and Family Services Division, Department of Human Resources, State of Oregon, 1981). Alpha Center. "Indigent Care Under Prospective Payment: The New York and Massachusetts Experiments," April, 1983. Alpha Centerpiece, August/September, 1983.

"Prepared for the Colorado Task
Force on the Medically Indigent,
January, 1984"

Appendix 2

DESCRIPTION OF EIGHT STATE
MEDICAL INDIGENCY PROGRAMS

DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*

PART I: WASHINGTON, OREGON, NEBRASKA, AND VIRGINIA

	WASHINGTON** (Population: 4,217,000)	OREGON (Population: 2,651,000)	NEBRASKA** (Population: 1,577,000)	VIRGINIA** (Population: 5,430,000)
Description of Program(s)	<ul style="list-style-type: none"> Medical assistance included in uniform, statewide General Assistance (GA) program for low-income incapacitated persons not eligible for federally subsidized assistance. Predominantly disabled, single adults. Medically indigent (MI) program covers low-income individuals not eligible for federally supported assistance or GA, but only for acute or emergent conditions and with \$500 deductible. Primarily nondisabled individuals, childless couples, and two-parent families. 	<ul style="list-style-type: none"> Medical assistance included in uniform, statewide General Assistance (GA) program for low-income unemployed single adults and childless couples not eligible for federally subsidized assistance. GA Medical Care Only program extends benefits to elderly, blind, or disabled persons who do not meet Medicaid income standards but incur medical expenses beyond their means. 	<ul style="list-style-type: none"> Medical assistance generally available through General Assistance (GA) programs funded and administered by all 93 counties for low-income persons not eligible for federally supported assistance. Coverage, payments, and policies vary among counties. Most populous county, Douglas County, has separate program for medically indigent funded by county and administered by the county hospital. Hospital acts as intake and referral agent. 	<ul style="list-style-type: none"> Medical assistance available in most localities through General Relief (GR) programs for certain categories of low-income persons not eligible for federally subsidized assistance. Partially funded by the state, the programs vary by county. Medical components are small and generally less comprehensive than Medicaid. Inpatient hospital care not included. State/Local Hospitalization (SLH) program provides for inpatient and some outpatient care to GR recipients and other low-income persons not eligible for federally subsidized programs. Funded 40% by state and 60% by counties.
Eligible Population	<ul style="list-style-type: none"> GA recipients automatically eligible for medical care. GA eligibility based on: <ul style="list-style-type: none"> - Income Standards: same as AFDC standards. Disregards for earnings and work-related expenses. - Employability: limited to persons with emotional, physical, or mental impairment who are not eligible for federally supported assistance. - Asset limits. MI program covers low-income non-disabled individuals with acute or emergent conditions and who are not eligible for federally supported assistance or GA. Income and asset limits with spend down (same as Medicaidly Needy) and \$500 deductible. 	<ul style="list-style-type: none"> GA recipients automatically eligible for medical care. GA eligibility based on: <ul style="list-style-type: none"> - Income Standards: Lower than AFDC and SSI standards. Special needs considered; reduced standards for some living arrangements. - Employability: limited to persons who cannot engage in gainful employment for a period of sixty days or more due to a diagnosed physical or mental incapacity. (Exception: single, employable women aged 50 or older who have received GA benefits since 8/75). - Asset Limits. GA Medical Care Only open to blind, aged and disabled persons with incomes over SSI (state supplement) standards but insufficient to cover medical expenses. 	<ul style="list-style-type: none"> GA recipients automatically eligible in most counties for medical assistance. Others may qualify if medical expenses cannot be met with available income. GA eligibility based on: <ul style="list-style-type: none"> - Income Standards: vary by county; generally lower than AFDC and SSI. - Employability: Employed and employable persons can usually receive aid if they meet income limits; job search generally required. - Asset limits vary by county; generally informal. 	<ul style="list-style-type: none"> GR recipients automatically eligible in localities providing medical care. GR eligibility varies by county and may include any number of optional groups, including the unemployed. Income standards generally lower than AFDC, but often include a work expense deduction. Assets are also considered. Medical assistance also available (in most localities) to recipients of short-term and emergency assistance component of GR programs. Income and asset standards vary by locality. SLH eligibility varies by locality and can be discretionary. State optional guidelines for income standards are higher than Medicaid standards, but generally followed only by large urban localities.

Appendix 2
DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*
PART I (Cont.)

	WASHINGTON**	OREGON	NEBRASKA**	VIRGINIA**
Benefits Covered	<ul style="list-style-type: none"> GA: Comparable to categorical Medicaid with some exceptions, such as hearing aides, some outpatient drugs, some mental health care, and out-of-state care. MI: More restrictive than Medicaid; comparable to Medically Needy (with exception of out-of-state care) but for acute and emergent conditions only. 	<ul style="list-style-type: none"> Both GA and GA Medical Care Only provide for same services as Medicaid, except fewer days of hospitalization are covered. 	<ul style="list-style-type: none"> Vary by county; generally discretionary depending on medical needs of client. Usually less comprehensive than Medicaid. 	<p>Vary by locality:</p> <ul style="list-style-type: none"> For GR recipients, all Medicaid services can be included except inpatient hospital care. For GR emergency recipients, any services (not limited to Medicaid services) can be included except hospital inpatient care. Inpatient and outpatient hospital care covered by SLH program.
Number Enrolled	<ul style="list-style-type: none"> GA: 9,900 (est.) monthly average in SFY 1982. MI: 1,905 (est.) monthly average in SFY 1982. 	<ul style="list-style-type: none"> GA: 4,271 monthly average in FY 1982 	<ul style="list-style-type: none"> Not available on statewide basis. 	<ul style="list-style-type: none"> GA: 91,498 cases in SFY 1982. SLH: Not available.
Program Administration	<ul style="list-style-type: none"> Both programs administered by State Department of Social and Health Services through 63 branch offices. 	<ul style="list-style-type: none"> Administered in conjunction with GA by State Department of Human Resources through 48 branch offices. 	<ul style="list-style-type: none"> Generally administered in conjunction with GA by county Boards of Public Welfare. Douglas county operates GA cash program through Department of Public Welfare but separate medical assistance program is administered by county hospital which acts as intake and referral agent. 	<ul style="list-style-type: none"> GR and associated medical assistance supervised by the State Department of Social Services (DSS) and administered by local departments of public welfare (124). Localities have wide latitude in establishing eligibility and benefits; some provide no medical care and many have very limited programs. SLH program supervised by DSS which establishes optional guidelines; localities determine actual eligibility standards and operate programs, some with less formal process than others.
Payment Method	<ul style="list-style-type: none"> GA: Vendor payments. Reimbursement procedure and rates same as Medicaid. MI: Vendor payments. Reimbursements made once eligibility is determined and \$500 deductible exceeded. Rates same as Medicaid. 	<ul style="list-style-type: none"> Vendor payments. Reimbursement procedure and rates same as Medicaid. 	<ul style="list-style-type: none"> Usually vendor payments. Reimbursement procedures and rates vary by county. 	<ul style="list-style-type: none"> Varies. Generally vendor payments for both programs. Sometimes medical payments included in GA maintenance check (for prescription drugs, for example).

DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*

PART I (Cont.)

	WASHINGTON**	OREGON	NEBRASKA**	VIRGINIA**
Program Financing	<ul style="list-style-type: none"> Both programs fully funded by state from general revenues. Funding is effectively open-ended; assistance available to all who qualify. 	<ul style="list-style-type: none"> Fully funded by state from general revenues. Funding is effectively open-ended; assistance available to all who qualify. 	<ul style="list-style-type: none"> Fully funded by counties. Funding is generally limited to yearly appropriation. 	<ul style="list-style-type: none"> GR: State reimburses localities for 62.5% of assistance expenditures and 80% of administrative costs. Funding at state level is effectively open-ended but local units vary in their resource commitments. Medical expenditures are small. SLH: Funds appropriated (fixed annual amount) by General Assembly on basis of county population to match local SLH expenditures. Unmatched funds revert to reserve used for counties needing more than yearly allocation.
Cost	<ul style="list-style-type: none"> GA: \$36,605,142 in SFY 1982. MI: \$10,378,872 in SFY 1982. 	<ul style="list-style-type: none"> \$13,009,128 in FY 1982. 	<ul style="list-style-type: none"> Not available on statewide basis. 	<ul style="list-style-type: none"> GR total (medical not available): \$12,311,697 in SFY 1982. SLH: Not available.
Recent or Proposed Changes	<ul style="list-style-type: none"> Between 1981 and 1983 changes included: elimination and subsequent reinstatement of MI program; reduction of MI deductible from \$1,500 to \$500 (may be reduced further); elimination and subsequent reinstatement of MW program. 	<ul style="list-style-type: none"> Legislature considering expansion of AFDC eligibility to Unemployed Parents option. Legislature considering Medicaid Needy Program under Medicaid. 	<ul style="list-style-type: none"> State recently came close to converting GA to uniform state-administered and state-funded program; associated medical assistance was to be supervised by state but funded by counties. Final compromise bill left GA and medical assistance with counties, but established requirements for county GA standards. State agreed to gradually assume full financial responsibility for Medicaid, 14% of which is currently funded by counties. 	<ul style="list-style-type: none"> State considering standardization of eligibility criteria for all non-federal medical assistance programs, including charity care offered through state teaching hospitals.

* For definitions of terms and abbreviations, see final table page.

** State has optional Medically Needy program under Medicaid (see text for explanation).

DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*

PART II: WYOMING, IDAHO, UTAH, AND COLORADO

	WYOMING (Population 492,000)	IDAHO (Population: 959,000)	UTAH** (Population: 1,518,000)	COLORADO (Population: 2,965,000)
Description of Program(s)	<ul style="list-style-type: none"> Minimum-Medical Program (MMP), fully funded by the state and operated by the counties, provides for medical assistance to low-income individuals not eligible for federally supported programs. Also covers drug costs for Medicaid enrollees and medical expenses of foster children in State's custody. Extent of medical care to indigents may be limited by state appropriation to county and requirement that funds be used first for drug costs and foster children. 	<ul style="list-style-type: none"> Medical assistance provided in conjunction with county funded and administered General Assistance (GA) programs for low-income persons. State requires counties to care for the medically or otherwise indigent, but not all counties provide GA, and eligibility and benefits vary. GA sometimes provides only for medical assistance and is often used as a supplement to Medicaid for AFDC and SSI recipients. 	<ul style="list-style-type: none"> State Medically Indigent Program (MIP) provides emergency medical assistance for low-income persons not eligible for federally supported programs. The program is state-administered, but counties participate on an optional basis and are required to contribute 1/4 mill annually to support program costs; the state pays 100% of additional costs. In FY 1982, 10 of the state's 29 counties participated. 	<ul style="list-style-type: none"> State Medically Indigent (MI) Program provides for medical care to low-income persons not eligible for federally supported programs. Administered by the University of Colorado Health Sciences Center, the program is limited to yearly appropriations and makes partial reimbursements to participating providers.
Eligible Population	<ul style="list-style-type: none"> General Assistance (GA) program recipients automatically eligible for MMP aid. GA, also fully funded by the state, requires for eligibility: <ul style="list-style-type: none"> - Income Standards: generally same as AFDC although counties may reduce standards on monthly basis depending on availability of funds. - Employability: employable persons are eligible but must register with state employment service. Employed adults eligible on temporary basis. - Asset limits. Others may qualify through spend-down at county option if funds are available. Medicaid program recipients qualify for drugs only through MMP. 	<ul style="list-style-type: none"> Varies by county. GA generally available to low-income persons with emergency medical and/or maintenance needs without regard to employment or employability. Eligibility is usually discretionary and made on case-by-case basis. Recipients are primarily disabled adults who receive medical assistance only. AFDC and SSI recipients in some counties can receive medical benefits to supplement Medicaid program which has limits on hospital days and prescription drug coverage. 	<ul style="list-style-type: none"> Eligibility determined separately from statewide General Assistance (GA) program. MIP open to indigent persons with acute or life threatening disorders or infections, who are not eligible for other assistance programs, and who have exhausted all other sources of aid such as relatives or church. Eligibility as follows: <ul style="list-style-type: none"> - Income limits: Same as for Medicaid except lower income deductions allowed and no spend-down for those with income above Medicaid levels. - Asset limits. 	<ul style="list-style-type: none"> Services available to persons who do not qualify for federally supported programs but who meet income limits. Eligibility and patient contribution to care determined by sliding fee scale with third-party coverage factored in to cover patients with minimal insurance coverage. Accessibility to program limited by location of providers.

DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*

PART II (Cont.)

	WYOMING	IDAHO	UTAH**	COLORADO
Benefits Covered	<ul style="list-style-type: none"> Same as Medicaid, plus prescription drugs which are excluded from state Medicaid plan. Counties have option of covering additional services. Catastrophic expenses generally not covered due to limitations of appropriated funds. 	<ul style="list-style-type: none"> Varies by county. No specified package of benefits; need determination is made on an individual basis. Medicaid services sometimes supplemented for AFDC and SSI recipients (i.e., hospital days and prescription drugs beyond limits). 	<ul style="list-style-type: none"> Less comprehensive than Medicaid. Provides limited hospital inpatient and outpatient care and other medical services for acute or life-threatening conditions. Some non-emergency care available in Salt Lake County through physician assistants at Health Department Clinics. 	<ul style="list-style-type: none"> Less comprehensive than Medicaid. Covers inpatient and outpatient hospital care, with priority to acute and emergent care.
Number Enrolled	<ul style="list-style-type: none"> GA: 400 (est.) in June 1982. Number of cases approved for MIP payment (including drugs) in June 1982: 167. 	<ul style="list-style-type: none"> Not available on statewide basis. 	<ul style="list-style-type: none"> GA (i.e. "potential eligibles"): 1,944 monthly average in SFY 1982. MIP: 2,605 persons received services in SFY 1982. 	<ul style="list-style-type: none"> Number served not yet available.
Program Administration	<ul style="list-style-type: none"> Administered by the Division of Public Assistance and Social Services (DPASS) through 24 county offices. County receives allocation based on population. Allocation can be adjusted if excess funds available from other counties. 	<ul style="list-style-type: none"> Usually administered by the county government under the direction of the county commissioners. 	<ul style="list-style-type: none"> MIP administered by the State Department of Health (Medicaid agency) through regional offices for participating counties. GA administered separately by State Department of Social Services. Some counties not participating in MIP operate their own medical programs for the indigent. 	<ul style="list-style-type: none"> Administered by University of Colorado Health Sciences Center, which contracts with participating providers.
Payment Method	<ul style="list-style-type: none"> Vendor payments. Reimbursement procedures and rates vary by county. 	<ul style="list-style-type: none"> Vendor payments. Reimbursement procedures and rates vary by county. 	<ul style="list-style-type: none"> Vendor payments. Reimbursement procedures and rates same as for Medicaid. 	<ul style="list-style-type: none"> Vendor payments. Reimbursements based on sliding fee scale and provider charges, but limited by yearly appropriation.

DESCRIPTION OF EIGHT STATE MEDICAL INDIGENCY PROGRAMS*

PART II (Cont.)

	WYOMING	IDAHO	UTAH**	COLORADO
Program Financing	<ul style="list-style-type: none"> Fully funded by state from general revenues. Funding is limited by yearly state appropriation. County required to pay for services in following order: (1) Foster children in State's custody; (2) Drug expenses for Medicaid recipients and others; (3) Other MIP assistance. 	<ul style="list-style-type: none"> Fully funded by counties with programs, through property taxes and general revenue sharing. Generally, funding is limited by yearly appropriations. 	<ul style="list-style-type: none"> Counties, which participate in MIP on optional basis, are required to levy 1/4 mill to contribute to program costs. State pays 100% of additional costs from general revenues. State funding is limited by yearly appropriations. 	<ul style="list-style-type: none"> Fully funded by the state from general revenues. Reimbursements limited by yearly appropriation. Providers receive portion of charges based on their share of statewide charges and total MI dollars available.
Program Costs	<ul style="list-style-type: none"> \$1,658,959 in SFY 1982. 	<ul style="list-style-type: none"> Not available on statewide basis 	<ul style="list-style-type: none"> MIP: \$2,331,061 in SFY 1982. 	<ul style="list-style-type: none"> \$16,500,000 (est.) for SFY 1983.
Recent or Proposed Changes	<ul style="list-style-type: none"> State considering uniform requirements for benefits and reimbursements. 	<ul style="list-style-type: none"> Several changes have been proposed, but not enacted, including: state-wide GA medical program with funding shared between states and counties; statewide catastrophic expense program with the counties pooling money on a cost per capita basis; Medically Needy program under Medicaid. Legislation was passed in 1983 to allow counties to levy taxes beyond a 1978 1 percent budget freeze, for medical indigent care only. 	<ul style="list-style-type: none"> State has considered mandating county participation in MIP program. 	<ul style="list-style-type: none"> 1983 legislation formally authorizes program; previously program was only a line item in appropriations bill. (For other changes enacted by House Bill 1129, see memo from Pat Butler dated June 29, 1983.)

* Definitions and Abbreviations:

- AFDC: Aid to Families with Dependent Children, a cash assistance program financed partly by the federal government and partly by the states.
- General Assistance (GA) or General Relief (GR): state and local cash assistance programs for such groups as low income single adults, childless couples, and intact families who are not covered by federally supported maintenance programs; often includes medical assistance.
- SFY: State Fiscal Year; FY: Federal Fiscal Year.
- SSI: Supplemental Security Income for the aged, blind, and disabled with low incomes, a cash assistance program fully funded by the federal government, except as states may choose to supplement the amounts.
- State has optional Medically Needy program under Medicaid (see text for explanation).

Sources: State populations from Statistical Abstract of the U.S. 1982-83, U.S. Bureau of the Census; 1981 state populations. Other information from state agencies and documents and: Urban Systems Research and Engineering, Inc. Characteristics of General Assistance Programs (Draft Final Catalogue prepared for Office of the Assistant Secretary for Planning and Evaluation, DHHS, 1983); Texas Advisory Commission on Intergovernmental Relations. Survey of State Programs and Policies on Medically Indigent Costs (Austin, Texas: May, 1983).

APPENDIX 3
RELEVANT CALIFORNIA DATA

TABLE 1
MEDI-CAL PROGRAM
AVERAGE MONTHLY ELIGIBLES BY PROGRAM AND AID CATEGORY
CALENDAR YEARS 1983 AND 1984

PROGRAM AND AID CATEGORY	CALENDAR YEAR 1983	CALENDAR YEAR 1984	CHANGE	
			Number	Percent
TOTAL	2,804,720	2,826,933	22,213	0.8
Public Assistance Program	2,365,959	2,382,253	16,294	0.7
Aged	282,652	279,368	-3,284	-1.2
Blind	18,176	18,781	605	3.3
Disabled	371,927	381,421	9,494	2.6
Families	1,693,204	1,702,683	9,479	0.6
Medically Needy Program	323,641	325,111	1,470	0.5
Aged	80,024	83,574	3,550	4.4
Blind	440	411	-29	-6.6
Disabled	26,729	30,214	3,485	13.0
Families	216,447	210,913	-5,534	-2.6
Medically Indigent Program	104,060	110,605	6,545	6.3
Adults	15,069	10,243	-4,826	-32.0
Children	88,992	100,362	11,370	12.8
Special Dialysis Program	94	78	-16	-17.0
Total Parenteral Nutrition Program	9	8	-1	-11.1
Refugee/Entrant Programs	10,957	8,878	-2,079	-19.0
CAPITATED HEALTH SYSTEMS ¹	212,215	247,881	35,666	16.8
Prepaid Health Plans	188,147	199,173	11,026	5.9
County Organized	24,068	48,708	24,640	102.4

¹ Included in the appropriate aid categories above.

NA: Not Applicable.

Note: Averages are rounded independently and may not add to totals.

Source: California State Department of Health Services, Medi-Cal Certified CID Eligibles, Calendar Years 1983 and 1984; Prepaid Health Plan Status Code 1 Reports; and Advance Payment Work Sheets for county organized health systems.

TABLE 2
MEDI-CAL PROGRAM
MEDI-CAL ELIGIBLES AS A PERCENT OF COUNTY POPULATION
FOR COUNTIES WITH TOTAL POPULATION OF 200,000 OR MORE
CALENDAR YEAR 1984

AREA	POPULATION ¹	ELIGIBLES ²	5%	10%	15%	20%	25%
CALIFORNIA	25,622,000	2,818,055					
Tulare	272,300	56,364					
San Joaquin	397,000	80,710					
Fresno	565,100	104,451					
Stanislaus	295,000	48,617					
Sacramento	866,200	138,542					
San Bernardino	1,032,000	134,630					
Los Angeles	7,909,300	963,028					
San Francisco	711,800	86,587					
Riverside	775,200	92,429					
Kern	461,500	54,942					
Alameda	1,176,800	131,070					
San Diego	2,068,000	184,699					
Sonoma	325,000	28,012					
Solano	265,300	22,676					
Monterey	319,700	26,289					
Contra Costa	698,600	56,831					
Santa Cruz	205,400	16,008					
Santa Clara	1,372,900	100,709					
Ventura	585,000	40,907					
Santa Barbara	322,600	21,462					
Orange	2,073,000	118,973					
San Mateo	607,200	25,286					
Marin	224,600	8,010					

¹ California Department of Finance, population estimate for July 1, 1984

² Average monthly eligibles excluding persons with special Refugee/Entry program aid codes.

Source: California State Department of Finance, Population Estimate for California Counties.

California State Department of Health Services, Medi-Cal Certified Eligibles, Calendar Year 1984; and PHP Status Code 1 Reports.

UC TEACHING HOSPITALS MANAGEMENT STUDY
PAYMENTS FOR IN/OUTPATIENT SERVICES
10 MOST POPULOUS CALIFORNIA COUNTIES
Fiscal 1983-84

County	Population As of Mid - 1984 A	Total AB 8 Allocation Per Capita B	Total County Net Expenditures Per Capita C	Percentage Funded by AB 8 ² D = B/C	County Net In/Outpatient Expenditures Per Capita E	PER CAPITA EXPENDITURES FOR IN/OUTPATIENT SERVICES				% Population Considered Poor in 1980 ^a
						Funded by AB 8 ⁴ F = D x E	Funded by County General Fund ⁵ G = E - F	WISP Allocations H	Total I	
SACRAMENTO	858,485	\$10.65	\$15.34	70.2%	\$ 9.55	\$6.71	\$2.84	\$20.56	\$30.11	11.2%
ORANGE	2,066,498	10.04	16.57	61.1	7.30	4.46	2.84	14.18	21.48	7.3
SAN DIEGO	2,040,888	6.03	12.07	50.9	7.40	3.76	3.64	17.81	25.21	11.3
Alameda	1,172,345	17.34	29.73	59.2	24.15	14.39	9.86	17.23	41.38	11.3
Costra Costa	683,670	15.28	23.04	66.8	14.36	9.60	4.76	12.76	27.12	7.8
Los Angeles	7,866,864	18.48	34.72	56.5	26.78	15.12	11.66	23.01	49.79	13.4
Riverside	757,470	12.39	21.11	59.9	7.53	4.51	3.02	21.38	28.91	11.3
San Bernardino	1,014,461	7.97	10.83	74.0	4.71	3.49	1.22	14.86	19.57	11.1
San Francisco	706,928	45.98	109.08	42.2	80.95	34.19	46.76	34.08	115.03	13.7
Santa Clara	1,365,120	11.46	16.62	61.9	10.15	6.28	3.87	12.33	22.48	7.1
Statewide	23,709,002	\$16.48	\$26.18	55.6%	\$18.34	\$10.19	\$8.15	\$18.71	\$37.05	11.4%

(1) Per capita allocation, based on entire population.

(2) Total per capita AB 8 allocation as a percentage of total per capita county health expenditures less revenues.

(3) County expenditures for in/outpatient services less related revenues. (Revenues do not include AB 8 funding.)

(4) Based on percentage of total per capita net health expenditures funded by AB 8.

(5) County net in/outpatient expenditures less portion funded by AB 8.

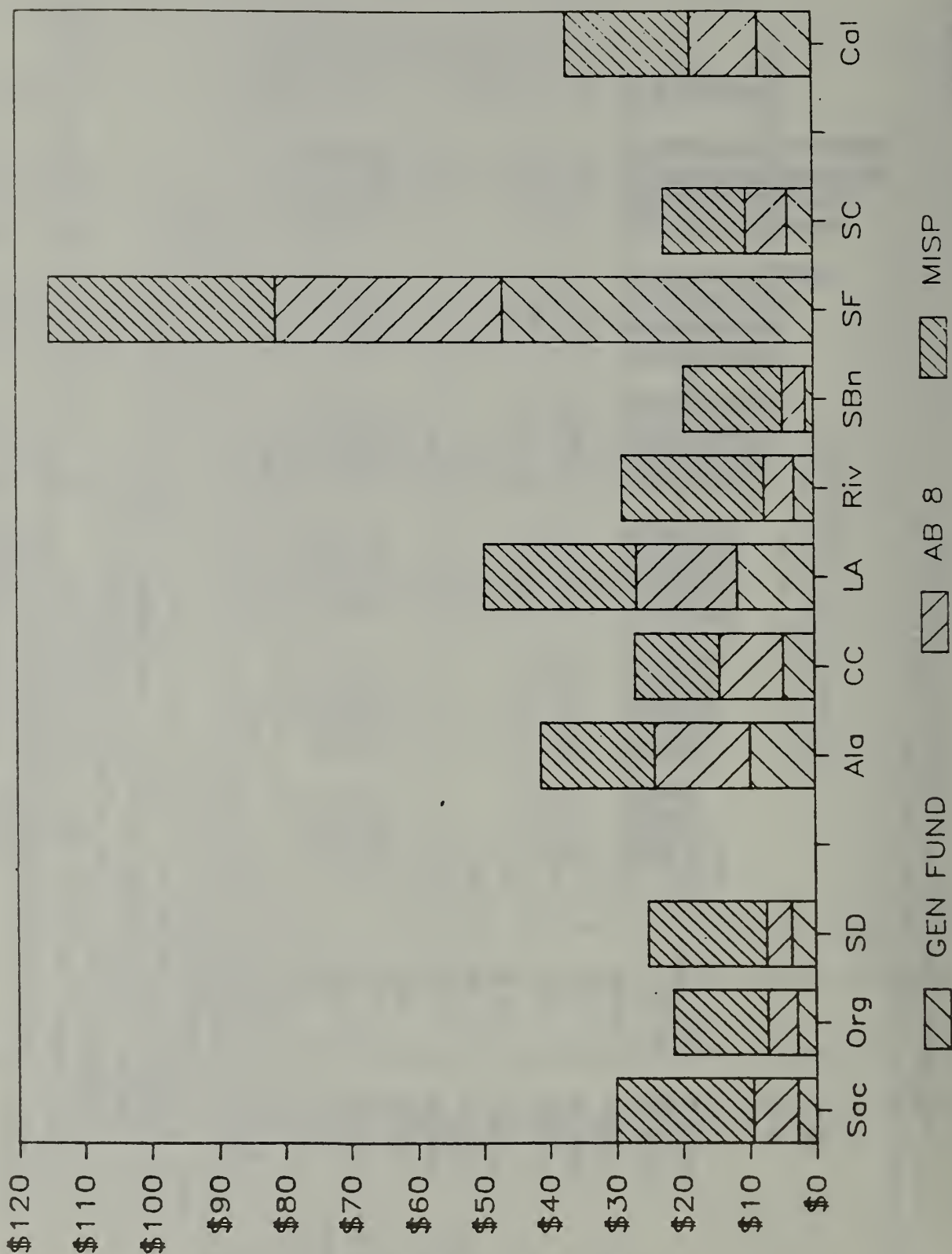
(6) Percentage of county population that was considered poor in 1980, based on figures from the federal census. Though more than five years old, the 1980 poverty figures are considered the most reliable available.

Source: Office of County Health Services, County Health Services Report, 1981/84
Department of Health Services
(1984-85 data is not available)

Figure 33

County Payments, In/Outpatient Services

PER CAPITA



A NEW PROPOSAL TO REFORM THE TAX TREATMENT OF HEALTH INSURANCE

by Alain C. Enthoven

Prologue: For the better part of a decade, Prof. Alain Enthoven of the Stanford University Graduate School of Business has been at the forefront of a growing movement to infuse the delivery of medical care with a structured form of price competition. Enthoven, an economist by academic training, has provided the intellectual lifeblood to this movement, educating a cadre of students who increasingly are finding their way into positions of influence, and impacting on the thinking of policymakers like former House Ways and Means Chairman Al Ullman (D-Ore.), Sen. David Durenberger (R-Minn.), Rep. Richard A. Gephardt (D-Mo.), and former Rep. David Stockman (R-Mich.). Enthoven, who set out his beliefs in a book entitled *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*, published in 1980, has been steadfast in his belief that the most appropriate remedy is not more bureaucratic controls imposed on, as he characterized it, "an inherently irrational system," but rather fundamental reform of the financing and delivery system itself. As he explained in his book, "... we need to change from today's system dominated by cost-increasing incentives to a system in which providers are rewarded for finding ways to give better care at less cost." Enthoven believes that government's role in this regard is not reorganization of the health care system by direct controls — as advocated recently in a presidential campaign speech by Democrat Walter F. Mondale — but changing the tax laws and Medicare and Medicaid laws that create the underlying incentives. Enthoven, a member of the Institute of Medicine of the National Academy of Sciences, was assistant secretary of defense under former Secretary Robert McNamara and has also served as president of Litton Medical Products.

The present favorable tax treatment of employer contributions to employee health benefits costs federal and state governments a large amount in foregone tax revenues—about \$30 billion in 1983. While tax incentives to purchase health insurance are desirable, there are four major problems with the present way the tax incentives are provided. First, it reinforces the cost-increasing incentives in our health care financing system and weakens consumer cost consciousness. Second, the distribution of the tax subsidies to health insurance is regressive. The present system provides substantial benefits for upper-income employed people, much less for low-income employees, and little or nothing for many self-employed, unemployed, and working poor. Third, the revenue loss to the government is growing much faster than the Gross National Product (GNP), thus contributing to the growing deficit. And fourth, the present system unnecessarily reinforces the link between jobs and health insurance.

In recent years, several congressional leaders have proposed a limit on tax-free employer contributions to employee health insurance and health benefits. The list includes Senator David Durenberger and Congressmen Richard Gephardt, James Jones, David Stockman, and Al Ullman. In 1983, the Reagan administration proposed a limit of \$175 per month for family coverage and \$70 per month for individual coverage, beginning in January 1984.¹ This limit would be increased annually in proportion to the Consumer Price Index (CPI).

The enactment of such a tax cap would be an important step in the right direction. It deserves support on its own merits. But there is an even better way to reform the tax treatment of health insurance, one that more effectively addresses all of the major defects of the present system: that is to replace the present exclusion of employer contributions from the taxable incomes of employees with a *refundable tax credit*. This tax credit would be equal to 40 percent of each taxpayer's health insurance premium payments to a qualified health care financing and delivery plan up to a limit on tax-subsidized premiums of \$150 per family or \$60 per individual in 1983 dollars. (This would be approximately the same as the Reagan administration's proposed limit expressed in 1984 dollars.) A qualified plan would have to meet certain federal standards which will be discussed later in this paper.

This refundable tax credit would be available to all legal residents regardless of job status or employer contribution. The limit should be increased annually in proportion to GNP per capita in order to stabilize the government's revenue loss as a share of GNP. This would replace a large and growing revenue loss that is tied to what amounts to open-ended entitlements in the private sector with a finite sum tied to the

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growth of GNP. It would equalize the subsidy—or incentive to insure—across the income classes. It would assist the self-employed, the unemployed, and the working poor to buy health insurance. Additional steps would be needed to assure universal access to affordable health insurance, but this would be a large step toward universal health insurance. The initial cost to the federal budget would not be large; the eventual savings would be.

The Present Tax Treatment Of Health Insurance

The Internal Revenue Code of 1954 excluded employer contributions to the health insurance and health care of employees from the incomes of employees subject to federal income and payroll taxes.² The states with personal income taxes have done the same. It is a safe bet that in 1954 nobody had any idea that Congress was enacting what twenty years later would become the second largest and one of the fastest growing federal health insurance programs. In FY 1975, according to Congressional Budget Office (CBO) estimates, the exclusion cost the federal budget \$6.9 billion; by 1983 it was \$25.7 billion.³ These amounts and their growth are compared with Medicare and Medicaid in Exhibit 1. In addition, Amy Taylor and Gail Wilensky estimated that in 1983 the exclusion cost states \$3.8 billion in lost tax revenue.⁴ CBO has projected that by FY 1987, the loss to the federal budget will be \$45.8 billion.

Exhibit 1

Growth In Federal Outlays And Tax Subsidies For Selected Health Insurance Programs (Billions of Dollars)

	FY 1975	FY 1983	Ratio 1983/1975
Medicare (a)	\$14.8	\$57.4	3.9
Federal Medicaid (a)	6.8	19.3	2.8
Exclusion (b)	6.9	25.7	3.7

Sources: (a) *The Budget of the United States Government, 1977 and 1984*; (b) Congressional Budget Office, *Containing Medical Care Costs Through Market Forces*, May 1982.

The favorable tax treatment of employer-provided health insurance has had the very beneficial effect of motivating the rapid growth of private insurance coverage. In 1950, seventy-seven million Americans, or half the population, had some insurance against at least hospital expense. By 1980, the number had increased to 189 million or 85 percent of the population.⁵ Data from the National Health Care Expenditures Study indicated that by 1977, 88.3 percent of employees in the United States worked for employers that offered health insurance plans.⁶ And the scope and depth of coverage of these plans have increased greatly.

A purely voluntary system of health insurance, based on individual decisions as to whether and how much to insure, would not produce results that would be acceptable in our society. In the absence of either compulsory health insurance or, what is almost the same thing, powerful financial incentives provided by government for people to buy insurance, the possibility of widespread health insurance would be destroyed by the process of adverse risk selection. Most medical care is elective with respect to timing. And individuals have private information about their health status and prospective health care needs that could be available to insurers only at very great cost, if at all. In a health insurance market made up solely of individual purchasers, and in the absence of powerful incentives for the healthy to purchase insurance (such as the tax subsidy in the exclusion), many individuals who expected no medical costs would either not insure at all or buy only insurance with very high deductibles and low premiums. Only those expecting medical expenses would buy insurance with low deductibles. When the well got sick, they would attempt to buy insurance. However, many would be unable to purchase insurance because insurers would exclude coverage for care of preexisting medical conditions. Premiums would be driven up to prohibitive levels, and insurance would become unavailable to many. Indeed, today the uninsured are heavily concentrated among those who do not belong to an employee group.⁷ This process would be exacerbated in our society by what economists call "the free-rider problem." Many people who expected no medical costs would not buy insurance and, instead, would plan to fall back on the public sector for care if they became seriously ill.

We could deal with these problems by a system of compulsory universal insurance financed directly by government, as in Canada or the United Kingdom. But in our country, we have chosen to deal with these problems, in the case of those who are neither aged nor poor, by a system of tax subsidies for the purchase of private health insurance, the effect of which makes it attractive for the healthy to insure. Thus, the issue is not the need for some form of tax subsidy. The issues are its form and distribution. It would be a serious mistake to propose the elimination of all tax subsidies for health insurance.

Defects In The Present Form Of Tax Subsidy

In its present form, the tax subsidy for health insurance has several serious defects. First, the present system reinforces the cost-increasing incentives in the health care financing and delivery system. In a group of average taxpayers, if the employer were to increase pay by \$100 per year, about \$40 would go to federal income and payroll taxes and state income taxes.⁸ If instead the employer were to raise the health benefits contribution by \$100 per employee, the full \$100 would go to health benefits.

The typical response is for employers and employees to agree that the employer will pay most or all of the employee's health insurance premiums with pretax dollars rather than paying the employee the equivalent amount in cash and leaving the employee to pay the premiums with net after-tax dollars. The incentive is also to cover very comprehensive benefits, including, for example, routine dental expenses, in the insurance plan so that even routine expenses will be paid with pretax dollars. For example, the number of persons covered by dental expense insurance increased from about twelve million in 1970 to over eighty million in 1980.⁹ Amy Taylor and Gail Wilensky have estimated that "employers pay 100 percent of the premium for almost half of the subscribers."¹⁰ The consequence has been to destroy the cost consciousness of the individual employee in medical purchasing decisions.

During the 1970s, as this process took place, more and more employers became committed to 100 percent payment of the cost of a comprehensive fee-for-service, free-choice-of-doctor insurance plan. As economical health maintenance organizations (HMOs) with lower premium costs than their traditional insurance competitors grew and became more widely available, it might have seemed rational for employers to peg their contributions to the cost of membership in an HMO, and to let the employees who wanted to do so pay the extra cost of the most costly plan themselves. However, only a minority of employers have done this. Most employers have been exceedingly reluctant to go back on a previously granted "entitlement." As a consequence, employees in such groups have little or no financial incentive to join an economical HMO.

Health insurance benefits have provided union leaders with a generous supply of bargaining prizes. Perhaps the union members who are less schooled in economic reasoning actually believe that it is the employer who is paying for these benefits, rather than employees in the form of reduced wages. On the other hand, those who are more schooled in economics probably recognize that health benefits are paid out of what would otherwise be wages, but they also recognize the large tax subsidy. Thus, the open-ended tax exclusion has given union leaders an additional and powerful incentive to bargain for 100 percent employer payment of a comprehensive package of benefits.

A new approach is needed to encourage employers and unions to reconsider these patterns of behavior. A change in the tax laws that limits the amount of employer contribution that could be tax free to the employee would help.

The second major problem with the exclusion in its present form is that it is regressive, and that it treats people of similar incomes and health insurance purchases differently merely by virtue of employment status. Paul Ginsburg estimated that in 1983 the exclusion was worth \$83 or .65 percent of income for households with incomes from \$10,000 to \$15,000,

but \$622 or .98 percent of income for households with incomes between \$50,000 and \$100,000. Part of the reason for this is that employer contributions are larger for the higher-paid group: an average of \$2,025 versus \$972 for households in these income categories receiving employer contributions. Employers of higher-income employees are much more likely to make contributions: 73 percent of households versus 31 percent for the two groups.¹¹ Part of the reason for this difference is that exclusions are worth more per dollar to people in higher tax brackets. Not only does this distribution of federal health insurance subsidies across the income classes seem inappropriate, but also there are "horizontal inequities." The present form of the exclusion does nothing for the self-employed or many other people who need and buy health insurance but do not have an employer contribution.

Of course, any tax deduction or exclusion will be more valuable to upper-income people because they pay taxes at higher rates. And one cannot make a fair appraisal of the equity of a particular provision of the tax code without considering the impact of the code in its entirety.

But, in effect, the tax exclusion has become a health insurance program, and it needs to be considered from the point of view of society's values concerning access to health care. It appears that we have a national consensus that everyone should have financial access to good quality health care and to health insurance at reasonable rates. Congress has expressed that in enactment of Medicare and Medicaid, other programs for special groups, continuation of the tax subsidy for the employed, and in attempts to pass health insurance programs for the unemployed. Nobody defends gaps in health insurance coverage. Yet, the present form of the tax subsidy encourages upper-income employed people to buy more health insurance while failing to help many who need it most, such as intermittently employed and self-employed persons. The irony is compounded by the fact that many low-income people without health insurance fall back on the public sector when seriously ill so that the taxpayers pay for their care anyway. It would make more sense to facilitate their purchase of private insurance in order to help them not become a burden on the public sector.

As noted earlier, a free unsubsidized market of health insurance for individuals breaks down because of adverse risk selection. To counteract this, a powerful financial incentive is needed to encourage the healthy to insure. Such an incentive is available to employed people. What rational basis can there be for denying the same benefit to those who are not employed?

The third major defect in the present form of the tax subsidy for health insurance is that the revenue loss to the federal government, already large, is growing much faster than the GNP. Paul Ginsburg estimated that the federal revenue loss increased from \$3.2 billion, or .34 percent

of GNP in FY 1970, to \$19.8 billion, or .7 percent of GNP in FY 1981.¹² This growth in relation to GNP has occurred for several reasons. First, health spending has grown faster than GNP, for example, from 7.5 percent of GNP in 1970 to 9.8 percent in 1981. Second, there have been marked increases in the scope of private health insurance. For instance, in 1970, as noted earlier, about twelve million persons had insurance for dental expense. By 1980, the number exceeded eighty million. And third, payroll tax rates have increased, and effective marginal income tax rates have increased as people were pushed into higher marginal tax brackets both by inflation and gains in real income. While the reduction in tax rates and the indexing of the tax brackets in the Economic Recovery Tax Act of 1981 (ERTA) will presumably stop the "bracket creep" associated with inflation, the other factors, including already-legislated future increases in payroll tax rates, will continue to increase the revenue loss if no corrective action is taken. In the future, this will become a more serious problem for the federal government than it has been in the past because ERTA deprived it of inflation-induced "bracket creep" as a source of revenue growth. ERTA will limit the growth in federal income tax revenue as a share of GNP to that which comes from growth in real per capita income.

The growth in this source of revenue loss is likely to be exacerbated by provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Social Security Amendments of 1983. In that legislation, Congress limited the growth in the amount per Medicare inpatient case that Medicare will pay to "market basket plus one percent," at least through 1985. At the same time, some states are engaging in selective contracting with hospitals at negotiated rates for Medicaid cases. If employers continue to make open-ended payments for fee-for-service medical care and for hospital charges on a non-negotiated, free-choice-of-provider basis, hospitals are likely to try to shift costs not paid by Medicare and Medicaid onto private payers. In that event, if government does not limit its tax subsidy to employer-provided health insurance, it is likely to end up paying 40 percent of the shifted costs through tax revenue losses. Government will become the main victim of the cost shift!

Finally, the present form of the exclusion reinforces the link between jobs and health insurance. This link adds greatly to the complexity of the health insurance market. For example, many people lose their health insurance when they lose their jobs. Those who work for an employer who self-insures or who buys an experience-rated policy from an insurance company are not likely to be able to continue their health insurance at their own expense, or if they are, it will not be at anything close to the group rate. HMO members who leave their employment group can continue their membership by continuing on their own to pay the community rate. But if an HMO member changes jobs and switches to an employer

who does not offer the HMO to his employees, the member is likely to be forced to change HMO and, probably, change doctors. A different form of the tax subsidy could ameliorate these problems considerably.

If one counts the tax subsidies, government is now paying about half the total cost of health care services. Yet we still do not have universal health insurance. Millions of people who do not belong to employment groups are denied the opportunity to buy health insurance and denied the subsidies available to employed people if they are able to buy insurance. Think of the problems of a widow or divorcee in less than perfect health who depended on her husband's employment group for health insurance. She is likely to become uninsurable or at least have coverage that excludes treatment for pre-existing medical conditions. In addition, she is denied a tax subsidy for health insurance. Can anyone put forward a rational defense of such a state of affairs? The plain fact is that our present system is an historical accident that is very hard to change because large numbers of influential people have a vested interest in the status quo. Congressional efforts to extend health insurance to the unemployed have failed, mainly because of budgetary problems, but also because of the problems of complexity of job-related health insurance and the lack of subsidies to support health insurance for unemployed people. We ought to be moving in the direction of universal health insurance, at least in the minimal sense of assuring each person the opportunity to buy health insurance at approximately a group rate.

The Proposed Reform

Congress ought to go beyond the tax cap and provide that every resident may receive a refundable tax credit equal to 40 percent of his or her own or the employer's health insurance premium payments to a health insurance plan meeting federal standards, up to a limit on subsidized premiums such as \$150 per family or \$60 per individual per month, in 1983 dollars. This would entirely replace the present exclusion. Employer payments would be included in the taxable income of the employee reports on Form W-2. A line would be added to the tax credit section of Form 1040. To substantiate the credit, the taxpayer would staple to the form a "Form H-2," a receipt from a qualified health plan. A "refundable tax credit" means that the taxpayer's liability is reduced by the amount of the credit, and in the event that the taxpayer's liability not counting the credit is less than the credit, the difference is refunded to the taxpayer in cash.

The credit would not be available to beneficiaries of Medicare and Medicaid. For persons covered by those programs for part of the year, the tax credit would be available for the months during which they were not covered by those programs. The tax treatment of employer-paid

health benefits for retired Medicare beneficiaries would not be changed by this proposal, but it should be reviewed and considered in its relationship to the Medicare program.

The limit would be increased each year in proportion to GNP per capita in order to adjust for inflation and to stabilize the cost to the government as a share of GNP. Since GNP per capita goes up faster than inflation, this allows for inflation plus an additional amount to help offset the effects of an aging population and advancing technology. (More precisely, the limit should be increased each year in the same percentage as the average change in GNP per capita over the past five years, in order to smooth out fluctuations.)

Reasons For The Proposal

First, this proposal would give everyone—including the healthy—a strong incentive to insure up to the limit, but a disincentive to buy a health insurance plan costing more than the limit. Those who bought less than the limit would be walking away from a subsidy. A family that did not insure would be turning down a \$60-per-month subsidy (40 percent of \$150). This incentive would be likely to attenuate the problem of adverse risk selection, described earlier, that makes it so hard to make health insurance available to individuals not part of an employment group, by giving healthy people an incentive to keep their insurance. However, it is not possible to predict, with presently available data, how effective this incentive would be. At the same time, this proposal would make every purchaser cost conscious in the choice of health care plan, and liable for the full premium cost above the subsidized limit. Families considering health plan alternatives with costs at or above the limit would be able to keep for themselves the full savings generated by the decision to choose the less costly alternative. Thus, enactment of this proposal would expand the demand for membership in cost-effective health care financing and delivery plans.

Second, this proposal would equalize the subsidy for health insurance across the income classes. The subsidy and the incentive to insure would become the same for high-income and low-income families. (Additional subsidies would be desirable for low-income families, but that issue could be considered separately and perhaps at the level of state and local government.) This proposal would treat equally two taxpayers with the same income and health plan, one of whom happens to have an employer while the other is self-employed. This proposal would also give the unemployed the opportunity to keep the health insurance they had when they were employed.

Third, this proposal would replace what amounts to an unlimited federal subsidy of privately negotiated open-ended entitlements with

fixed-dollar subsidies that would grow at the same rate as the GNP. Thus, *it would help to balance the budget in the long run.*

Why should the limit be around \$150 per family per month in 1983 or \$175 in 1984? The idea is to provide every family an incentive to subscribe to a good quality comprehensive but economical health care financing and delivery plan. Ideally, from a health insurance point of view, if we were dealing with a single market, the limit would be set at the price of the least costly comprehensive health care financing and delivery plan. That would assure everyone subsidized access to comprehensive care. However, there are other factors to consider including regional variations and political judgments about support and priorities. For 1984, \$175 was the Reagan administration's choice. A similar approach would be that used in Sen. David Durenberger's Health Incentives Reform Act of 1979: a limit equal to the average premium cost for federally-qualified HMOs.¹³ That stood at about \$172 per family per month in mid-1983, which, when adjusted for inflation, would yield a somewhat higher figure for 1984. However, there is no compelling reason why the limit must match 100 percent of the average HMO premium.

Why make the credit 40 percent of the limit? This is a judgment call reflecting several factors. First, 40 percent is approximately the average marginal tax rate, including both income and payroll taxes. Thus, the position of the average taxpayer belonging to a 100 percent employer-paid plan with a premium at the limit would be unchanged. Lower income people would gain, above-average-income people would lose. Second, a substantial subsidy, about that large in my judgment, would be needed to motivate most healthy people to buy fairly comprehensive insurance plans, and thus combat the adverse risk selection problem described earlier. If cost and budgetary considerations rule this out, Congress might try a lower percent as an alternative. Somewhere not far below 40 percent, a "budget neutral" proposal could be designed.

Why should the tax credit be refundable? The purpose of the proposal is to encourage low-income people to insure even if they have little or no tax liability. The limit should be applied to the tax-paying unit—the individual or couple filing a joint return—and not to the employer. There are millions of two-earner households, even millions of two-job people. As a result, roughly fifty million people have duplicate coverage which is costly and can defeat the cost-reducing incentive effects of coinsurance.¹⁴ Some people collect duplicate insurance payments and don't pay tax on them. A family doesn't need two \$150-per-month tax shelters; one per family is enough.

Should there be regional adjustments to reflect differences in factor costs? This is essentially a political question. The proposal ought to be enacted with or without regional adjustments for factor costs. Regional adjustments have often been proposed and debated. One reason for

them is to prevent hardships for people in high-cost areas, and windfalls for people in low-cost areas. Another is to give recognition to the fact that, at equal tax rates, people in higher wage areas pay higher taxes. On the other side, there is no precedent for regional adjustments in the tax laws. To create regional adjustments in the tax credit, it is argued, would open Pandora's Box and unleash a free-for-all scramble for all sorts of regional preferences. Another argument for uniformity is that regional variation would add to complexity of administration. However, it would not need to be more complicated than a table of limits by state in the tax-return instructions. Finally, one could argue that the uniform limit hits hardest where needed most, in the high-cost areas.

In the new Medicare system of prospective payment to hospitals by diagnosis-related group (DRG), regional hospital wage differentials are recognized and will be allowed to persist. Personally, I would prefer to see Congress define the tax credit as a health insurance program and allow regional variations for factor costs. But I do not think the value of this proposal depends critically on that provision.

Why index the limit to GNP per capita? The overall CPI has been criticized as overly sensitive to such factors as the impact of interest rates on housing costs. The trouble with using the medical care component of the CPI is that this would help reinforce the inflationary cycle. The use of GNP per capita instead of the GNP deflator recognizes that such factors as advancing technology and an aging population create valid reasons for increasing real per capita spending, and that stabilizing health care spending as a share of GNP is a sufficiently ambitious goal. Congress could review this periodically in relation to other priorities.

Additional Reforms That Could Be Tied To Tax Credits

While the change in the tax treatment of health insurance could stand on its own merits, I would recommend tying it to some other changes intended to promote universality and continuity of coverage and to facilitate competition among health plans. In order for premium payments to be eligible for the refundable tax credit, health care financing and delivery plans should have to meet certain standards.

First, a qualified plan should be required to offer people who leave an employment group the right to purchase the same coverage at their own expense at rates not to exceed, for example, 110 percent of the group rate, the excess to cover extra administrative costs. The same right should be available to dependents who lost coverage because of death or loss of employment of the employee, divorce from the employee, or loss of dependent status because of age or graduation from college. This right should be exercisable without medical review or exclusion of coverage for pre-existing medical conditions. (The employer's obligation could be

cancelled by the employee's joining another employee group offering a qualified health insurance plan.) Self-insured employers could discharge this obligation by providing the coverage themselves or by contracting for it with an insurance carrier. I recognize that such a requirement is not without cost to employers. But continuity of coverage is an important social purpose that government would be paying to achieve by the tax subsidy.

The main argument against such a requirement is that the per capita costs of insuring people who leave an employment group are quickly driven up by adverse risk selection. People who lose their jobs and don't expect any medical needs drop their health insurance, while those expecting to need medical care keep theirs. One of the purposes of the proposed tax credit is to attenuate this process of adverse risk selection by giving healthy people an incentive to continue their insurance. If necessary, Congress could compromise the implementation of this principle by enacting a time limit such as a year.

Additional measures would be required to assure universal availability of health insurance. But continued subsidies to people leaving employment groups and continuation of their right to buy insurance at approximately the group rates would be a major step in the right direction. Congress and/or state legislatures might consider a subsequent step of contracting with HMOs and insurers to offer insurance to persons not eligible for group coverage, while subsidizing the excess risk component of the cost of such coverage. (That is, insuring people who are not members of a group costs more than insuring a group of similar age-sex composition because of the adverse risk selection associated with individual coverage. Estimates of this excess risk component can be made by reference to the average cost of insuring group members. A government agency could negotiate to pay a subsidy to a health plan to induce it to offer coverage to individuals at group rates.)

It is worth noting that HMOs presently allow members who leave their employment group to continue their coverage at their own expense at the community rate. Because I belong to an HMO, my child can purchase individual coverage at the community rate without medical review or exclusions for pre-existing medical conditions when he or she ceases to be my dependent. The same would be true of my widow in the event of my death. Congress should require that whatever health insurance contribution an employer makes should be equally available to a new employee who wishes to retain membership in his HMO, whether or not the employer offers coverage by that HMO.

Continuity of coverage standards should include the requirement that coverage for dependent children begins automatically at the time of birth or adoption, and that employer group plans contain no exclusions or restrictions on coverage based on pre-existing medical conditions. Exclu-

sion of coverage of care for pre-existing medical conditions is a means that health insurance companies use to protect themselves from medical costs of chronically ill people and from "the free-rider problem," in which people do not buy health insurance until they become sick. While understandable from an individual company point of view, this practice is indefensible from a social point of view. It means denying health insurance to the people who need it most. If there were a general ban on exclusion of care for pre-existing conditions, individual companies would not need to suffer a worsened competitive position by dropping such exclusions. Similar continuity of coverage provisions were included in Sen. David Durenberger's Health Incentives Reform Act, first introduced in 1979.¹⁵

Next, every qualified plan should be required to meet at least a common standard of services covered and limits on out-of-pocket payments. The standards defined by the HMO Act of 1973 would be a good point of reference. However, many people would feel that the HMO Act and regulations define a coverage that is too costly and comprehensive. If Congress were to decide that this is the case, it could adopt a less costly standard. But to achieve a fair competitive market, all qualified health plans, including HMOs, should be required to meet the same standard. Because of the problem of risk selection in a competitive market, choice of benefit package has to be a social and not an individual decision. Health plans that wish to offer more extensive benefits may do so, but at their own risk of attracting an adverse selection of health risks attracted by the more generous benefits.

There are several reasons for requiring a common standard of coverage or "benefit package." The first is to prevent deceptive or inadequate coverage, "swiss cheese" insurance policies with gaps in coverage that insureds only discover when they need health insurance. (An example would be coverage of newborns not beginning until ten days after birth.) The second is to discourage the use of the benefit package as a tool to select preferred risks. One insurance plan can always select better risks than another by offering a higher deductible and lower premium. Those consumers not expecting to need medical care will find it to their advantage to take the lower premium. Eventually, only health plans with very high deductibles would survive. Third, health insurance policies are very difficult to understand and compare. If left without controls, insurers can differentiate their policies in such a way as to make valid price comparisons very costly. A simple way to focus competition on price, quality, and accessibility of care and service is to standardize most of the fine print that most people can't understand and can't remember anyway.

Cost To The Federal Budget

The following estimates of costs and savings are based on 1983 levels of spending and assume a 1983 limit on subsidized premiums of \$150 per month for a couple filing a joint return and \$60 per month for an individual.

Several assumptions need to be specified. First, these estimates assume that the limit is applied to each taxpaying unit, as I have described above. Second, this proposal includes no change in the tax treatment of employer-paid insurance for Medicare beneficiaries and their supplemental policies. Third, Medicaid beneficiaries would be unaffected by this proposal. They would not receive tax credits in the months in which they are covered by Medicaid.

The gross cost of the tax credits in 1983 dollars, assuming the 1983 pattern of health insurance premium expenditures, would be \$31.1 billion.¹⁶ If we assumed that every eligible person were to take full advantage of the credits—a state that would require at least several years to be reached—the gross cost in 1983 dollars would be \$38.4 billion.

Offsetting these costs would be the increases in tax revenue realized by including all employer contributions in the taxable incomes of employees. The increased federal income tax revenues at 1983 levels would be \$19.5 billion. The increase in federal payroll tax revenues would be \$6.5 billion.¹⁷ Assuming all states with personal income taxes followed suit, increased state income tax receipts would be \$3.8 billion. The federal government would need to negotiate with the states to recapture these savings by making offsetting reductions in grants to states. The estimated impact on the federal budget would depend on what one assumes about the action of Congress to recapture these revenues.

Combining these numbers, one can derive a “worst case” first-year estimate of the cost to the federal budget of \$12.4 billion, that is \$38.4 billion (assuming all eligible people take full advantage) less \$26 billion (assuming Congress does not recapture the increased state income tax revenues). And similarly, on the opposite assumptions, one can derive a “best case” estimate of \$1.3 billion, that is \$31.1 billion less \$29.8 billion.

I believe the “best case” is closer to the truth at the outset, because Congress could, in effect, recapture the increased revenues of the states by offsetting reductions in grants, and because it would take several years for all eligible people not now insured to find ways of obtaining health insurance. Moreover, under this proposal, the revenue loss from the present unlimited exclusion, which is growing at a rate that about doubles its share of GNP in a decade, would be replaced by a tax credit keyed to grow with the GNP. Thus, whatever net revenue loss there might be at the outset should be regarded as a modest investment to achieve important long-run savings.

And if Congress were still not satisfied with that, it could phase in the tax credit, starting with, perhaps, 35 percent instead of 40 percent of premium payments, or with a lower limit on the subsidized premiums. In other words, as noted earlier, a version of this proposal could be devised that would be "budget neutral" in the short run and cost saving in the long run.

Some Problems With The Proposal

As is the case with any proposed change in public policy, this one is not without its problems. First, what about high-risk groups, people who have high premium costs because they are older or in occupations that lead to high medical needs? A limit on the tax subsidy could penalize them unfairly. To solve this problem, it would be necessary to vary the subsidies by actuarial rating category and to require every health plan to practice community rating by actuarial category. I proposed this in Consumer Choice Health Plan.¹⁸ Community rating means charging the same premium for the same benefits regardless of the health status of the groups or individuals covered. Under a scheme of community rating by actuarial category, the population is divided into groups based on factors that predict medical need. Health plans can charge higher premiums for covering people in higher risk categories. This compensates the health plan for serving people in higher risk categories. These people, in turn, can be protected from the burden of higher costs by the government paying proportionately higher subsidies on their behalf. The best example of this idea in actual operation is the recently tested and enacted system under which Medicare pays HMOs for caring for its beneficiaries. Medicare will pay the HMO 95 percent of the Adjusted Average Per Capita Cost (AAPCC), which is the average cost to Medicare of similar persons who remain with fee-for-service, considering age, sex, location, institutional status, and other factors. Some kind of system to compensate health plans for serving higher risk persons, while protecting the patients from the higher costs, is a necessary part of any system of fair economic competition of health care plans. It might be appropriate to begin with a simple stratification based on subscriber's age, such as under/over forty-five, and eventually phase in a more refined system.

Next, there is the question of probable employer response. Under the "tax cap" proposal, I believe the most probable response of employers now contributing more than the limit would be to make fixed-dollar contributions to employee health insurance at the tax-free limit, and to pay the employees the rest of what they were contributing in cash. Under the "tax credit" proposal, employer payments for health insurance would be included in the employee's taxable incomes. So employers might just as well pay the employees cash as health insurance contributions. Would

this destroy the employer incentive to organize health insurance for employees? Or would it cause employers to lose interest in what health insurance costs? I think not. Availability of good health insurance options would remain an attractive fringe benefit employers would want to offer to attract employees.

Next, there is the problem of windfall loss for those employees now receiving large employer contributions to costly health plans. Some auto workers, for example, are receiving employer contributions in excess of \$300 per month. Under the tax credit proposal, an employee previously receiving \$300 per month tax free would suffer a \$720-per-year increase in tax liability (assuming he is in the 40 percent marginal bracket). Nobody should be subjected to a sudden large and disproportionate loss by a change in the tax laws. Usually Congress deals with this kind of problem by including "grandfather clauses" or transition rules. Such provisions would be appropriate in this case. For example, an employee might be allowed to retain an individual limit on tax-subsidized health insurance premiums equal in dollar amount to the employer's contribution in 1983 until the increase in GNP per capita caught up to that amount. Of course, one must acknowledge that, to the extent individuals are protected from increased tax liabilities by transition rules, the initial net budgetary cost of the proposed tax credit will be higher.

One of the purposes of this proposal is to create market conditions more favorable to the growth of cost-effective comprehensive care organizations by making buyers cost conscious in their choice of health plan. Under the present "employer pays all" mode, there is often little or no incentive to make an economical choice. Some leaders of the HMO movement are concerned that the tax-subsidized amount might not keep up with the costs of a comprehensive plan. To see the potential problem, imagine that the subsidized limit were \$50 per family per month rather than \$150. Some insurers would then offer policies with a \$50 monthly premium and a deductible high enough to make that possible. People expecting no medical costs would choose a high deductible. People expecting substantial medical expenses would choose comprehensive plans such as HMOs. HMOs would be destroyed by adverse selection. This is a matter of particular concern to HMOs because the federal HMO Act requires them to cover comprehensive benefits, but does not place similar requirements on other health insurance plans.

One answer to this concern is that tying the limit on the subsidized amount to the growth in GNP per capita should allow for continued real growth. Even so, if health care costs continue to rise much faster than GNP per capita, the medical purchasing power of the subsidized amount could erode. Congress should review the program periodically to prevent excessive erosion. Another safeguard would be the common benefit standard applied to all health care plans qualifying for the subsidy.

HMOs would then be subject to the same rules as their competitors and not forced to offer more comprehensive coverage.

What about administrative expense? Under the tax credit the IRS would see millions of new "H-2 forms." A new line would be added to Form 1040 for a new tax credit in addition to the eight already there. Millions of people who do not now file tax returns would do so in order to receive their refundable tax credit. Employers who do not now allocate health insurance expenses on a per employee basis would have to do so. They would have to allocate on a per individual or family unit basis and by geographic area when there are significant differences. As an accounting problem, this would be no more complex than most. This cost needs to be judged in the context of the problem of rapidly rising health care costs, the gains in efficiency that could be achieved in a more cost-competitive health care economy, and the great complexity of regulatory solutions to health care cost problems. I believe the efficiency gains would far outweigh the costs of administering the tax credit. And I think it is inevitable that the federal government will have to act somehow to bring the growth in its revenue losses associated with tax subsidies to health insurance into line with the GNP.

Finally, some argue that limiting the exclusion is unnecessary because some employers are beginning to add coinsurance and deductibles and otherwise reduce previously granted open-ended entitlements. In the absence of a change in the tax laws, I doubt that this will be a very pronounced trend. Putting in a \$250 deductible, for example, is not a very draconian cost-control measure. Other reports indicate strong resistance by unions to any cuts in health benefits.¹⁹ Absent a change in the tax laws, it is hard to see why employers and employees would find it in their interest to agree that the employee pay a greatly increased share of health care costs with net after-tax dollars. In any event, the proposed refundable tax credit also addresses other deficiencies in the present tax treatment of health insurance.

Conclusions

In sum, replacement of today's open-ended exclusion of employer contributions from the taxable incomes of employees with a refundable tax credit equal to 40 percent of each individual or family's premium payments to a qualified health care plan, up to a limit of 40 percent of \$60 or \$150 in 1983 dollars, would make subsidies for the purchase of health insurance universally available to those who could buy insurance. This would attenuate the adverse risk selection problem that now plagues attempts to cover individuals not in groups. Combined with continuity of coverage requirements for qualified health plans, this would facilitate continued coverage for the unemployed.

At the same time, the tax credit would make buyers cost conscious in their choice of health plan, and thus replace an important cost-increasing incentive with a reward for an economical choice. This would represent a major and favorable change in the health care economy from the point of view of demand for membership in cost-conscious health care plans. And the tax credit would distribute public subsidies for the purchase of health insurance more equally across the income classes and within income groups, as between the employed and others.

The tax credit approach would greatly reduce the "Medicaid notch" — the loss in public subsidy that a Medicaid beneficiary suffers when he or she increases his or her earnings enough to exceed the eligibility limit. The tax credit approach would also bring the growth of the federal revenue loss from tax subsidies to health insurance into line with the growth of the GNP. And the tax credit could be used as a lever for some socially desirable rules for fairer competition among tax-favored health care financing and delivery plans.

NOTES

1. Statement of Robert J. Rubin, M.D., Assistant Secretary for Planning and Evaluation, DHHS, before the Senate Finance Committee, 22 June 1983.
2. Internal Revenue Code, sec. 105 and sec. 106.
3. Paul B. Ginsburg, *Containing Medical Care Costs Through Market Forces*, Congressional Budget Office (May 1982).
4. Amy K. Taylor and Gail R. Wilensky, "The Effect of Tax Policies on Expenditures for Private Health Insurance," in Jack A. Meyer, *Market Reforms In Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983).
5. Health Insurance Association of America, *Source Book of Health Insurance Data* (Washington, D.C.: HIAA, 1982-1983).
6. Amy K. Taylor and Walter R. Lawson, Jr., "Employer and Employee Expenditures for Private Health Insurance," *Data Preview 7*, National Center for Health Services Research, National Health Care Expenditures Study, U.S. DHHS Publication No. (PHS) 81-3297.
7. Maureen Baltay, *Profile of Health Care Coverage: The Haves and Have-Nots* (Washington, D.C.: Congressional Budget Office, March 1979).
8. Ginsburg, in *Containing Medical Care Costs*, estimates that in 1983, the average federal marginal tax rates that would apply to employer contributions if they were taxed was 38 percent.
9. Health Insurance Association of America, *Source Book*.
10. Taylor and Wilensky, "The Effect of Tax Policies."
11. Ginsburg, *Containing Medical Care Costs*.
12. Ginsburg, *Containing Medical Care Costs*.
13. *Health Incentives Reform Act*, 96th Cong., 1st sess., 12 July 1979, S.Rept. 1425.
14. Marjorie Smith Carroll and Ross H. Arnett II, "Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment, and Financial Experience," *Health Care Financing Review* 3 (September 1981).
15. *Health Incentives Reform Act*.
16. Personal communication from Amy K. Taylor. Estimates based on the 1977 National Medical Care Expenditure Survey. See Taylor and Wilensky, "The Effect of Tax Policies." Dr. Taylor's preparation of these estimates is gratefully acknowledged.
17. See Taylor and Wilensky, "The Effect of Tax Policies." This calculation excludes the tax revenue loss associated with the exclusion of employer contributions to the health insurance of retired Medicare beneficiaries, estimated conservatively at \$900 million.
18. Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, Mass.: Addison Wesley Publishing Company, 1980).
19. "Moves to Cut Health-Care Benefits Meet Stiff Opposition from Unions," *Wall Street Journal*, 26 October 1983.

HEALTH TAX POLICY MISMATCH

by Alain Enthoven

Prologue: The favorable tax treatment of employer-provided health insurance has had the very beneficial effect of motivating the rapid growth of private insurance coverage. Data from the National Health Care Expenditures Study estimated that by 1977, 88.3 percent of employees in the United States worked for employers that offered health insurance plans. But the cost of this tax incentive, which is most generous to employed upper-income people, has escalated by many billions during a period when the federal government has squeezed medical spending for the old and poor. These foregone tax revenues now represent the federal government's second largest health program, as the administration's 1986 spending estimates document: Medicare \$73 billion; tax expenditures \$24 billion; Medicaid \$24 billion; veterans medical care system \$9 billion; and the National Institutes of Health \$5.5 billion. In this essay, Professor Alain Enthoven of the Stanford University Graduate School of Business puts forward a sharply higher estimate of the revenue loss that will result from this favorable tax treatment and then explains why. Enthoven, an economist by training, has provided much of the intellectual lifeblood for the movement toward the use of market principles in health care delivery. But, interestingly, his relationship to the Reagan administration, which believes fervently in market approaches, has been, at best, arms length. For the better part of a decade, Enthoven has been promoting comprehensive medical care delivery reform through the marriage of two ideas: (1) the creation of a network of competitive medical plans which would operate under economic incentives that encourage efficiency and (2) the development of a regulatory framework that insures the operation of these plans on a basis which comports with the best interests of society. The administration has embraced the first idea, but considered the second to be in conflict with its determination to deregulate government. The administration supports the placement of a ceiling on the deductibility of employer contributions to employee health benefits, but the tax revision bill recently approved by the House Ways and Means Committee retains the exemption.

The federal budget for fiscal year 1986 estimates the "tax expenditure" (tax revenue loss) from exclusion of employer contributions for medical insurance and medical care from the taxable incomes of employees at \$23.7 billion.¹ The likely revenue loss will be about twice that.

Three developments lead to this conclusion. First, while the official definition of "tax expenditures" refers only to income tax revenue losses, and not payroll tax revenue losses, there will still be payroll tax losses which, if the Treasury's income tax revenue loss estimates were correct, would be about \$10.2 billion.

Second, the Health Care Financing Administration has recently increased the previously estimated volume of private health insurance by about 18 percent.² The previous estimates did not adequately reflect the large growth in employer "self-funded" insurance plans, many of which are "self-administered" or managed by third-party administrators and not reported by insurance companies. This change was published in December 1984. It is apparent, and not surprising, that the Treasury's figures, published in February 1985, do not reflect this.

And third, a very important event took place in May 1984, when the IRS clarified the status of "cafeteria plans" including "salary reduction" and "flexible spending arrangements" under Section 125 of the Internal Revenue code.³ According to the IRS ruling, employees may have their health insurance premium contributions paid with pretax dollars by making salary reduction agreements with their employers, or by setting up flexible spending accounts (FSAs). FSAs can be used to tax shelter employee premium contributions and out-of-pocket medical expenses. According to the IRS ruling, the amount in the FSA must be specified in advance and cannot be changed during the tax year. And the account must be "forfeitable" or on a "use or lose it basis," that is, the unused amount at the end of the year, if any, cannot be returned to the employee.

Flexible Spending Accounts

Salary reduction or FSAs are an ideal device for employees to use to tax shelter their health insurance premium contributions. The administration of such a payroll deduction is very simple. The premium contribution is predictable, so the "use it or lose it" restriction is no constraint at all. The employer has strong incentives to offer it. For one, he can avoid the employer's share of payroll tax on the sheltered amount. Moreover, use of this procedure breaks the link between the payment that is characterized as "employer contribution" and the tax break, making it easier for the employer to limit the growth in his contribution without denying the tax break to his employees.

Policymakers in Washington are only beginning to appreciate the po-

tential this ruling creates for tax sheltering premiums and out-of-pocket expenses. For example, federal employees must pay their premium contributions with net-after-tax dollars. The federal government may well continue to deny its employees the opportunity to tax shelter their contributions through "salary reduction" or FSAs. But the spouse of a federal employee working in the private sector may pay his or her spouse's premium contribution through an FSA set up with the private employer.

One can only guess at the speed with which use of this device will spread, but it seems reasonable to suppose that within the next year or two, the great majority of employers and employees will be using it at least to tax shelter health insurance premium payments. So the figures I will present here are estimates of the potential loss, assuming that people take advantage of an easy tax break. The actual loss may take a little longer to catch up.

Before the IRS ruling, it was normal to estimate or assume that about 80 percent of the premiums of employer-sponsored insurance was paid by the employer, hence tax sheltered, while about 20 percent was paid by the employee out of net-after-tax income. If 90 percent of employee contributions are sheltered this way, 98-percent of premiums in employer-sponsored insurance will be tax sheltered. This would raise the amount of revenue lost to the federal budget by 22.5 percent. Adding the \$10.2 billion payroll tax loss to the \$23.7 billion income tax loss, and increasing the total successively by 18 and 22.5 percent, one obtains a revised estimate of \$49 billion of revenue loss in 1986.

The revenue the Treasury will lose through tax sheltering of employer contributions to health insurance can be estimated directly. The total volume of private health insurance premiums in 1983 has recently been estimated at \$110.5 billion.⁴ The president's budget forecasts 1986 gross national product (GNP) at 30 percent above that of 1983. For many years, health spending and health insurance have grown faster than the GNP. However, the growth of employer cost containment, competitive medical plans, and Medicare prospective payment are having an impact. Growth with the GNP would seem a reasonable basis for a forecast. That would put 1986 premium volume at about \$144 billion.

Tax sheltering through employment. Most, but not all of this, can be tax sheltered through employment. But there is uncertainty and some disagreement over certain categories. In making their estimate of revenue loss, federal officials assume that about 82 percent of the aggregate premiums can be tax sheltered. This produces a very conservative estimate, and, in my view, a substantial underestimate. Most of the remainder is in "individual" coverages, that is, contracts directly between the insurer and the insured individual, and coverages through "association groups." Examples of the latter are state bar associations, Granges, associations of realtors, accountants, and the self-employed. To be sure, a self-

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employed person in the IRS definition of the term may not tax shelter his or her health insurance premium except as an itemized deduction to the extent that it is a part of medical expenses that exceed 5 percent of adjusted gross income. So it is easy to understand how one might assume that many independent professionals and small business people cannot tax shelter their premiums. However, many of the people insured through association groups are employees, such as associates and secretaries in law firms.

There are at least four ways in which a self-employed professional or business person might tax shelter health insurance premiums and out-of-pocket expenses through FSAs. The first is to incorporate, as many have done. The second is to form an employment relationship with a client and have the "employer" pay the premium in lieu of cash. The third is to put one's spouse on the payroll as an employee, and to pay his or her family coverage. The fourth is to obtain coverage through one's spouse's employment. All four of these practices exist today. The new IRS interpretation of Section 125 increases the incentive to use one or another of them. I believe it is likely that most of the people covered through association groups and a substantial number of those covered through individual policies soon will have tax sheltered their premiums if they have not already done so, and that at least 90 percent of total premium volume is susceptible to tax sheltering, possibly more.

Official federal estimates of revenue lost are based on a marginal income tax rate for the average taxpayer in 1986 of 25 percent, and a combined income and payroll tax rate of 33.34 percent. But a Congressional Budget Office (CBO) study showed that most of the tax-free dollars go to households with incomes above the average, suggesting that a higher marginal tax rate such as 36 percent is applicable.⁵ These figures yield potential revenue loss estimates that range from about \$39 billion to \$47 billion for 1986.

Estimating the potential revenue loss from the use of FSAs to shelter out-of-pocket expenses is inevitably much more speculative than estimating the revenue loss from tax sheltering premiums because there is so little experience with the former. The administrative costs are higher and the procedures are more complicated than for sheltering premium contributions. But the FSA for out-of-pocket expenses, even of the "forfeiting" variety, opens up very large potential revenue losses to the Treasury. It is reasonable to suppose that given a little time to get used to the idea and a normal amount of American ingenuity, many regularly employed Americans, especially those in higher tax brackets, will figure out how to get much of their health care spending paid for with pretax dollars via FSAs. The "forfeiting" restriction is likely to end up being much less restrictive than appears at first glance.

Consider the opportunity as seen by the employed head of household.

Let us say it is December and he or she must direct the employer to reduce his or her salary by a specified amount for the coming year and put that into a medical FSA. The employee estimates the family's needs. First, if this year's FSA is exhausted, how many bills can be delayed until next year, perhaps by delaying completion of a course of treatment? Next, many expenditures can be planned for the coming year. Most surgery is elective with respect to timing. Cosmetic surgery not normally covered by insurance can be planned and included in the FSA. Also, coinsurance and deductibles can be paid out of the FSA, as can glasses, hearing aids, and drugs. In considering the dangers of overestimating, the taxpayer knows that if the end of the year is approaching, he can decide to accelerate payments to some providers or start some elective treatments earlier (for example, have the children's eyes examined and buy new glasses.) There may develop a market for "health insurance" policies for which you pay in December which cover you for 90 percent of the premium amount until the account is exhausted. Underestimates can be compensated by delaying payment or services to the next year. The IRS will disallow some of the maneuvers if it can find them. For example, it will doubtless say that expenses must be incurred in the year in which they are deducted. But the problem of enforcement will be formidable.

A study team in the Department of Health and Human Services recently estimated that the annual revenue losses associated with the sheltering of out-of-pocket expenses through the forfeiting FSAs will grow to \$7 billion (in 1983 dollars) over the next several years.⁶ This was based on a detailed analysis that seems as reasonable as any under the circumstances. So we are facing total potential revenue losses in 1986 of the order of \$46 to \$54 billion.

Imbalances In Present System

While Congress struggles to cut a few hundred million dollars of spending from Medicare and Medicaid, it ignores a gaping loophole on the revenue side. The Congress and the IRS have created this loophole without setting prior limits on its cost, either per person or in aggregate, and even without knowledge of what it would cost. Yet the cost to the budget of this item will soon rival Medicare!

This illustrates a very great imbalance in the treatment of expenditure items and revenues or "tax expenditures." Politically, the tax break is counted as "tax reduction." It reduces tax revenue as a percent of GNP. Explicit subsidies for the purchase of health insurance count as outlays. Thus, converting from a "tax expenditure" to "on budget" expenditures of the same amount would raise reported taxes and spending as a percent of GNP, though the effect on the deficit would be the same. Indeed, if the explicit expenditures were in fixed dollar amounts, their effect in

distorting resource allocation would be far less than the effect of the present system of tax subsidies. If all employer contributions were included in taxable incomes, and the government subsidized private health insurance through explicit budget outlays, one can be sure that subsidies of this magnitude, distributed in this manner, would never have been enacted.

Why do we have such a tax break? The real reason is historical accident combined with political power of the main beneficiaries. The Internal Revenue Code of 1954 ratified a practice that had grown up during World War II when employer contributions to health insurance and other fringe benefits were exempted from wartime wage controls. They were also excluded from taxable incomes. It would be hard to believe that anyone in 1954 had any idea of the eventual consequences for the health care economy or the budget of excluding employer contributions to health insurance from taxable incomes. But once such a tax break has been granted, powerful vested interests grow up in support of it, and it becomes extremely difficult to change.

Those who defend this tax break do so with the argument that the incentive that it provides to insure is necessary to ensure widespread medical care coverage. Given a choice between cash and medical care coverage without a tax subsidy, young or healthier people and those with low incomes would often choose cash over insurance. This would lead to a process called "adverse selection" in which the healthy would drop coverage, and the cost for all those who retain coverage would be raised. This in turn would cause more people with below-average expected medical expenses to drop out, raising the premiums still further, in a cycle that would eventually destroy health insurance altogether.

Indeed, just such a process is a major contributor to the fact that roughly 30 million Americans, largely those who do not belong to a regular employment group, are without any medical care coverage today.⁷ A powerful incentive is needed to make coverage attractive to the healthy so that they will insure and help hold down premium costs for the rest.

As a description of the consequences of a lack of incentives for the healthy to insure, this argument is accurate and persuasive. The trouble is, there is a gross mismatch between this rationale and our actual tax policy. In actual fact, the tax incentives are targeted on the wrong people. The tax incentives are most generous to employed upper income people. In fact, because of our progressive tax system, the higher the income, the greater is the tax subsidy to a person's health insurance. Because they have incomes and assets to protect, one can be sure most high-income employed people would buy health insurance even if there were no tax subsidies.

On the other hand, the tax subsidies are small or nonexistent for many people who need help the most: the part-time employed, the intermittently employed, the self-employed, the unemployed, and those employed in

marginal industries whose employers do not provide health insurance, and the widows and divorcees who lost their health insurance when they lost their husbands. If these people can get health insurance at all, as well as having to pay for it with higher individual premium rates, many of them have to pay for it with net-after-tax income. These are people whose decisions whether or not to buy health insurance are influenced by its cost. If one believes that federal tax policy ought to be used to promote the spread of private health insurance, then these are the people on whom the tax incentives should be targeted.

A study by CBO estimated that in 1983, 88 percent of tax-free employer contributions went to households with annual incomes over \$20,000.⁸ The median household income that year was \$20,885.⁹ The tax benefit averaged \$622 per household in the \$50,000-\$100,000 income range, but \$83 per household in the \$10,000-\$15,000 range.

In addition to giving upper income households more powerful incentives to insure, because they are open-ended, the tax subsidies reinforce the cost-increasing incentives in the health care financing and delivery system. They reduce the marginal cost to the employee of each extra dollar's worth of health insurance and thereby induce employment groups to buy cost unconscious open-ended comprehensive insurance. The tax system tells upper income groups that if they decide on still more costly benefits, government will pay 40 to 50 percent of the extra cost.

The present tax treatment of health insurance has been one of the main causes of the paradoxical situation that millions of people are overinsured and causing inflation in health care, while millions of other people are underinsured or have no coverage at all. The irony and irrationality of this is compounded by the fact that through the open-ended tax subsidy, the government is subsidizing the efforts of people with above average incomes to bid up the prices and standards of care that the uninsured must then pay for directly and that the government must pay for through Medicare and Medicaid. Government is subsidizing its own competition for resources!

Changing The Incentives

These considerations suggest that the social policy goals of incentives and subsidies for medical care coverage ought to be stated more precisely. And the actual tax policy should be tailored to match the goals. As a statement of goals, I would recommend that we seek to motivate and help everyone, whether employed or not, to purchase a good quality comprehensive cost-effective health plan, and to discourage people from purchasing an inefficient overly costly health plan. The policy that would fit this goal would be to subsidize everyone's purchase of health care coverage up to a limit judged to correspond to the price of a good quality

cost-effective plan, and not to subsidize choice above that limit.

This is not a radical new idea in 1985. Important steps in this direction have been embodied in legislative proposals by some of the most thoughtful and fiscally responsible members of Congress for at least the past six years. In July 1979, Sen. David Durenberger (R-MN), now chairman of the Health Subcommittee of the Senate Committee on Finance, introduced the Health Incentives Reform Act of 1979 which would have, among other things, limited tax-free employer contributions to an amount equal to the average HMO premium. Subsequent versions of that bill set a specific dollar limit, indexed to inflation. Also in 1979, former Rep. Al Ullman (D-OR), then chairman of the Ways and Means Committee, introduced the Health Cost Restraint Act of 1979, which would have, among other things, limited tax-free employer contributions to \$120 per family per month, indexed to the consumer price index. In June 1980, Rep. James Jones (D-OK), subsequently chairman of the House Budget Committee, introduced the Consumer Health Expenses Control Act which would have, among other things, limited tax-free employer contributions to \$100 per family. In March of 1983, Sen. Robert Dole (R-KS), then chairman of the Finance Committee, introduced his Health Cost Containment Tax Act of 1983 with a 1984 limit on tax-free employer contributions of \$70 per month for individual coverage and \$175 per month for family coverage, again indexed to the consumer price index. This approach was supported for several years by the Reagan administration and was included in the Treasury's first tax reform proposal in December 1984.

These tax cap proposals would have saved the budget billions of dollars and would have greatly improved the economic rationality of the financial incentives in the health care system. But by themselves they would have done nothing for the self-employed and others without tax-free employer contributions. This year Senator Durenberger introduced S.1211, the Health Equity and Fairness Act of 1985, which contained some very substantial improvements over previous tax cap proposals. While this bill put a limit on tax-free employer contributions of \$100 per month for individual coverage and \$250 per month for family coverage, indexed to the GNP deflator, it extended the same deduction to individuals, so that, for example, those who do not have tax-free employer contributions could receive the same tax incentive to insure.

As I pointed out earlier, the people who need the most incentive and help with the purchase of health insurance are those with low incomes. People with high incomes have incentives to insure because they have incomes and assets to protect. The trouble with the deduction or exclusion approach is that it is worth more to people in higher tax brackets, much less to people in low brackets.

Therefore, I believe that the Congress ought to go beyond the ap-

proach of these bills and create a refundable tax credit or direct subsidy to qualified health plans equal, for example, to 40 percent of premium payments up to a limit on subsidized premiums of \$60 per month for an individual, \$120 for a couple, and \$180 for a family in 1986, indexed to GNP per capita. Such a credit would be equally valuable to a person with a low income as to a person with a high income. It would give everyone an incentive to buy a health plan up to the subsidized limit, but would make them fully cost conscious above that limit. (The credit would replace the exclusion.¹⁰) Such a subsidy could also be of considerable assistance to state and local governments in their efforts to arrange insurance for the uninsured.

Excluding Medicare and Medicaid beneficiaries who are subsidized separately, these credits, if fully used, would cost the budget about \$47 billion in 1986. Over the long run their cost would grow with the GNP, not faster. And the cost consciousness this restructuring would foster would ease the problems of cost growth in Medicare and Medicaid. Thus, the favorable impact on the federal budget would be substantial, including a savings of as much as \$7 billion in the first year.

This reform would represent a long step toward universal health insurance. Additional steps to make subsidized insurance available to low income people would be needed, but this could be done in the context of a competitive, economically rational, and decentralized private market.

If we cannot match our tax policy to the stated objective of promoting widespread health insurance by providing subsidies to low-income people and those without employer-paid health insurance at least equal to those provided to upper income people, then Congress should abolish the tax subsidy altogether, and divide the savings between reducing the budget deficit and giving explicit subsidies to purchases of health insurance by low-income people. Our health care economy would perform better with no tax subsidies to health insurance than with the mismatched subsidies now costing the budget so much.

NOTES

1. Budget of the United States Government, FY1986, Special Analysis G (Washington, D.C., 1985), p. G-46. The Treasury's figure is for the fiscal year. My estimates are for the calendar year. The difference is within the margin of error of all these estimates.
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3. IRS, "Tax Treatment of Cafeteria Plans," *Federal Register* (7 May 1984), 19322-29.
4. Arnett and Trapnell, "Private Health Insurance."
5. Paul B. Ginsburg, "Containing Medical Care Costs Through Market Forces" (Washington, D.C.: Congressional Budget Office, May 1982). In this study, the "average taxpayer" was in the 33.4 percent combined marginal bracket, but because of the distribution of employer contributions, the applicable weighted average marginal tax rate for these payments was 37.6 percent.
6. "A Study of Cafeteria Plans and Flexible Spending Accounts" (Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, DHHS, May 1985).
7. See, for example, "Financing Indigent Health Care," *Employee Benefit Research Institute Issue Brief Forty-Four* (Washington, D.C.: EBRI, July 1985).
8. Ginsburg, "Containing Medical Care Costs." This number is implicit in the data in Table 2, p. 27.
9. Bureau of the Commerce, *Statistical Abstract of the United States, 1985* (Washington, D.C.: 1985), 442.
10. For more detail, see Alain C. Enthoven, "A New Proposal to Reform the Tax Treatment of Health Insurance," *Health Affairs* (Spring 1984).

SENATE SYMPOSIUM ON UNCOMPENSATED HEALTH CARE AND
ACCESS FOR THE UNSPONSORED AND INDIGENT PATIENT

REMARKS OF C. DUANE DAUNER
PRESIDENT
CALIFORNIA HOSPITAL ASSOCIATION

June 20, 1986

I appreciate the opportunity to address you this morning on behalf of the California Hospital Association.

We applaud the Senate and its Coalition on Health Care for sponsoring this important and timely Symposium. Adequately and equitably meeting the health care needs of California's indigent residents is a public policy issue requiring prompt resolution. It has been 20 years since establishment of the Medicare and Medicaid programs, which were intended to provide the necessary resources to enable the poor and the elderly to obtain mainstream health care. Yet, 20 years later, we find ourselves facing a rapidly growing population of undersponsored and unsponsored indigent patients. These patients have restricted access to health care services, and when they do receive care, the provider often receives little or no payment.

The California Hospital Association is vitally concerned about this emerging crisis. A CHA Task Force on Uncompensated Care recently issued its report detailing a strategy for dealing with this problem. I will review the major findings and recommendations from that report, in addition to commenting on current legislative initiatives.

Uncompensated Care Represents Greater than a Billion Dollar Annual
Loss to California Hospitals

Uncompensated care represents the cost of charity care, bad debts and unreimbursed Medi-Cal costs. Today's uncompensated care crisis is a consequence of the combined effects of:

- (1) Medi-Cal underpayments, exacerbated since enactment of the contracting program;
- (2) Transfers of responsibility for medically indigent adults from the state to the counties;
- (3) Legislated Medi-Cal eligibility and coverage restrictions;
- (4) The Medicare prospective payment system;
- (5) Changes in private payment practices, including selective contracting, initiated through AB 3480 in 1982;
- (6) National and international economic pressures, and
- (7) Undocumented aliens.

Uncompensated care affects all elements of society; however, its immediate impact on the unsponsored poor and the hospitals that care for them is direct and severe.

Solutions will not come easily. The federal deficit and the so-called Gann budget limit at the state level compounds the problem. Increased pressures will be placed on local governments and the private sector. However, the public responsibility for alleviating

this problem must be acknowledged. Uncompensated care results from public policy and should be borne by society as a whole. Hospitals cannot be the primary funding source of care for patients who are financially disadvantaged.

In 1985, California hospitals provided approximately \$1 billion in uncompensated care. This amount is staggering when compared to total 1985 costs of \$15 billion.

Uncompensated Care is Concentrated in Especially Vulnerable Institutions

This billion dollar plus problem is not distributed evenly among California's more than 540 community hospitals and has potentially disastrous consequences for some hospitals. Significantly, uncompensated care is concentrated--60 percent of the uncompensated care is provided in 12 percent of the hospitals, making these institutions particularly vulnerable. Many of these disproportionate share hospitals are operating at a loss. Failure of these vital institutions will result in major access problems for all indigent patients, sponsored as well as unsponsored.

This problem is immediate and demands action to resolve the crisis for hospitals which are incurring a disproportionate share of losses because of their commitment to care for the poor and financially disadvantaged.

The Uncompensated Care Crisis can be Traced Primarily to Two
Developments-- Medi-Cal Cut-Backs and the Increasingly Competitive
Health Care Environment

The tremendous cutbacks in 1982 brought forth a sizable group of indigent disenfranchised patients--from shifting responsibility for the Medically Indigent Adults to the counties with inadequate funding which has further declined in real dollars, and restricting benefits and eligibility. The price-competitive nature of the health care industry makes it next to impossible for some hospitals to subsidize uncompensated care from paying patients and other sources. The 1982 reforms have already resulted in General Fund savings to the Medi-Cal program of about \$734 million according to the California Medical Assistance Commission. A good portion of these savings and an equivalent savings to the federal government came at the expense of California's poor and the hospitals which provide their care.

Since 1982, the aggregate Medi-Cal contract rates paid to hospitals have not increased because of the state's "no-net increase" policy. This squeeze will cause disenfranchisement of patients and preclude provision of services to needy patients who should qualify for Medi-Cal or public assistance.

It is no secret that hospitals bearing the greatest burden in caring for the state's unsponsored and undersponsored poor are county hospitals, children's hospitals and certain other institutions. In addition to disproportionately high mixes of unsponsored and Medi-Cal patients, these hospitals lack the ability to offset their losses from treating privately sponsored patients.

County hospitals are precluded from running a deficit or incurring costs for optimum care which will not be subsidized. They have been able to survive thus far by delaying and deferring capital projects, purchases, renovations and modernization. County hospitals' care to the unsponsored and undersponsored poor is provided without adequate capital replenishment and, thus, at the expense of future patients and taxpayers.

California and the nation have pursued a distorted policy of marketplace healthcare, with an obsession of controlling public program expenditures. The other half of the competition equation, as originally formulated by its architects during the 1970's, was to provide access for all to an array of competitive health insurance plans, with government subsidies available to those who need them to cover the premiums. This important piece of the competitive puzzle has been ignored.

The state and federal governments fail to recognize a pro-competitive health policy as one where risk and market-place incentives are employed to create a cost-effective health system, so that the public receives the best value for its expenditures. A public policy

directed toward using government's power to arbitrarily squeeze providers, while virtually ignoring the growing population of individuals falling through the cracks, is not building a competitive health system. Rather, it is creating a system destined to fail society in the long run.

By its very nature, a competitive market environment makes it increasingly difficult for hospitals to balance the conflicting objectives of caring for the poor and economic survival. To preserve the favorable aspects of marketplace health care, it is essential for public policy to assure access to needed services for the growing population falling through the cracks and to provide relief for those institutions on which the undersponsored and unsponsored poor are dependent. Failure to adequately address the problem will eventually lead to abandonment of the marketplace approach in favor of a highly-regulated, bureaucratically controlled health care industry.

A Recommended Uncompensated Care Policy

The California Hospital Association recognizes the significant and growing unsponsored population and the resulting levels of uncompensated care as problems requiring both immediate and long-term actions.

While the California Hospital Association policy in this area is still evolving, we believe the following principles are essential for meeting the health care needs of indigent patients:

1. Health care services for poor and financially disadvantaged patients are the responsibility of society.
2. Payments for health care services to such patients should be funded from public sources which are broad-based and represent a fair spread of the cost throughout society.
3. High-quality, medically necessary health care services should be accessible to patients unable to pay.
4. Payments to health care providers should be adequate to cover the cost of care.
5. A system of incentives should be established to encourage providers to render care to unsponsored patients and maintain access for patients unable to pay.

The problem requires immediate action to give urgently needed relief to hospitals providing disproportionate amounts of uncompensated care. The majority of unsponsored patients depend on these disproportionate share providers for their care. The CHA Uncompensated Care Task Force report recommends a program for immediate implementation which involves the following elements:

1. Establish a state and federally-financed fund to provide annual relief to disproportionate share hospitals. We estimate that \$500 million is needed to initially establish this fund.

2. Since uncompensated care is a societal obligation, the relief fund should be financed from the general fund and, to the extent possible, tied to the Medi-Cal program to maximize the use of federal matching monies. (State and federal law and regulations provide for special consideration for disproportionate providers through the Medicaid program.)
3. Disproportionate share providers should be those hospitals which have bad debts, charity care and uncompensated state and locally sponsored patient costs as a percentage of total hospital expenses in excess of the statewide mean. This would qualify approximately 145 hospitals for relief.
4. A uniform definition of uncompensated care should be promulgated, along with appropriate reporting and auditing requirements.
5. Relief should be based on actual costs and should be distributed statewide on a sliding scale formula which brings all disproportionate share hospitals down to the statewide average (6.8% in 1983).

For a longer-term solution, the following points should be considered:

1. Public programs should be restructured and extended to include as beneficiaries people who are uninsurable, underemployed and underinsured, unable to provide for their care and those such as undocumented persons who do not qualify for government-sponsored programs.

2. Initiatives should be increased to strengthen the incentives to obtain adequate private health insurance coverage through the workplace for all family members and increase the availability of affordable private health insurance to both employers and individuals.
3. Funding should be a state-federal responsibility, from a broad base of tax support.
4. Incentives should be incorporated to encourage providers to participate, thereby maintaining access to high-quality health care.
5. Payments to providers should be adequate and fair.

Comments with Regard to Pending Legislation

There are a number of bills currently in the Legislature attempting to deal with aspects of the uncompensated care and indigent access problem. They range from regulation of hospital transfers, to factors to be considered by the Medical Assistance Commission in granting rate increases, to mandating a comprehensive study of the problem, to expanding access to private health insurance, and to creating a fund for indigent care through a state tax on cigarettes.

Two bills, AB 3403 (Margolin) and SB 1607 (Maddy), address the issue of economic transfers of emergency patients. We are supportive of the intent of AB 3403 and have been working with the author to resolve our concerns with some aspects of the bill. SB 1607 was recently amended to address transfers. Both bills are directed toward dealing with a symptom of the bigger problem--the increasing number of unsponsored patients. Public policy, which has created a growing pool of unsponsored indigent patients and promoted the deliberate underpayment for services required by publically-sponsored patients, is the major underlying cause for the perceived need to regulate the treatment and transfer of indigent patients.

Senate Bill 1312 (Carpenter), sponsored by the United Hospital Association, addresses the need for the opportunity to negotiate a cost of living increase for Medi-Cal contracting hospitals after a virtual four-year freeze in payment rates. One factor the Medical Assistance Commission would consider in negotiating individual increases is the hospital's proportion of uncompensated care. This is definitely a move in the right direction, by at least providing some minor relief for disproportionate providers.

Senate Bill 1159 (Bronzan) addresses the serious undercompensation by Medi-Cal for outpatient services. This much needed bill would provide for augmented payments to disproportionate share hospitals.

Senate Bill 636 (Maddy) covers Medi-Cal underpayment to small and rural hospitals. The bill would increase outpatient payments to small and rural hospitals and provide for relief from the Medi-Cal Inpatient Reimbursement Limit (MIRL). Small and rural hospitals are among the most vulnerable in the industry to undercompensation by government payors and to uncompensated care costs. Their patient utilization is low, their population base is insufficient to offer competitive alternative services, most are sole community providers, and their margin is so fragile that their survival is threatened.

In addition to seeking budget augmentation for SB 1312, AB 1159, and SB 636, the hospital industry has been unified in support of additional funding for Medi-Cal inpatient contracts for disproportionate share hospitals and increased funding for the badly underfunded Medically Indigent Services Program which partially compensates counties for providing care to former Medi-Cal eligible Medically Indigent Adults. We are encouraged by the Legislature's response to date to these bills and to our budget augmentation requests.

CHA and the California Association of Public Hospitals are the co-sponsors of Assembly Bill 3132 (Bronzan) which calls for a task force to study the problems of access to health services for the unsponsored poor and issue a report analyzing the problems, examine options and recommend solutions. CHA supports an objective and comprehensive study of this issue. We further recommend that, as a component of this effort, the task force develop estimates of health service and resource requirements to meet the needs of the

unsponsored, Medi-Cal and the county-sponsored populations. It is important that an independent body make a determination after careful study of the funding necessary to meet society's obligations to its needy population. The Legislature and the Governor, in appropriating funds for medical care, should have available the best information on the level of funding necessary to meet certain objectives. Then, if they decide to fund these programs at a lower level, they will be able to make explicit trade-offs in coverage, eligibility and benefits, of which the beneficiary and provider communities will be aware.

Assembly Bill 600 (McAlister) would create a mechanism to make affordable private health insurance available to previously uninsurable individuals. Funding would come from a tax on disability insurance and on entities providing health coverage. This bill is complex and ambitious. However, we support the overall intent. It has the potential to reduce the number of unsponsored patients, it does not address coverage for indigents per se. AB 600 does not fully address the problem of uncompensated care. It attempts to partially deal with the issue. Immediate problems facing disproportionate hospitals are not addressed, and should be dealt with in the manner I discussed earlier.

Finally, Senate Bills 2425 and 2426 (Torres) sponsored by the California Association of Catholic Hospitals, which are in Interim Study, would establish an indigent care relief pool through a state tax on cigarettes. Funds would be distributed from this pool to

hospitals based on their level of charity care. The distribution formula is designed to provide incentives to all hospitals to provide care to unsponsored patients.

None of the bills now pending comprehensively address the fundamental issue of societal provision for the health care needs of uninsured or underinsured patients. In the next year we must all face the challenge of developing comprehensive, yet feasible approaches to the growing problem of uncompensated care.

On behalf of the hospitals in California, I wish to again express my appreciation for the opportunity of sharing our concerns and recommendations with you. We are anxious to work with you in developing a solution to the uncompensated care problem and access to health care.

PRESENTATION FOR THE

SYMPOSIUM ON

UNCOMPENSATED HEALTH CARE

AND

ACCESS FOR THE UNSPONSORED AND

INDIGENT PATIENT

BY: FREDERICK ARMSTRONG, M.D.
PRESIDENT-ELECT
CALIFORNIA MEDICAL ASSOCIATION

JUNE 20, 1986

"UNCOMPENSATED HEALTH CARE
AND
ACCESS FOR THE UNSPONSORED
AND INDIGENT PATIENT"

The CMA appreciates the opportunity to present our views on "Uncompensated Health Care and Access for the Unponsored and Indigent Patient." Unfortunately, we must predict bad times ahead for poor and near-poor patients, unless the effects of recent government and private sector trends are corrected. Specifically; (1) additional government cutbacks in health programs at all levels of government, and (2) policies favoring "competitive" health insurance products, are promoting even further limitations on access to quality health care, particularly those with low-income. Groups adversely affected are Medi-Cal recipients, Medicare eligibles, indigents, the uninsured, "self-pay" patients, and the under-insured, for they are most likely to not pay, or significantly underpay, their medical bills.

Uncompensated care is an extremely complex issue for State policy makers; one that involves determining the appropriate roles of patients, providers, insurers, and government in paying for the health care of those who can't pay. Let us pose the question "As current trends continue, how will the costs of patients who can't afford to pay for needed medical care be allocated?"

Private insurers and government entities are, today, avoiding the legal moral and responsibility for their share of uncompensated care costs (even though they are best able to spread the cost to the general population). Conversely, the burden of uncompensated care is increasingly falling onto a few providers and, of course, the patients who can not pay. Ultimately, government bears the burden because poorly insured beneficiaries become indigent patients when their benefits are exhausted.

This paper will highlight; (1) the recent government policies and economic trends which led to today's problem, (2) the effect on California physicians and other providers, and finally (3) the effect on patients.

I. RECENT TRENDS IN HEALTH CARE DELIVERY

A. CUTBACKS IN GOVERNMENT PROGRAMS

Since the 1960's, government has played a significant role in financing health care for the poor. However, in the past few years, efforts to balance budgets at all levels of government have resulted in drastic reductions of government funding for health programs.

The federal government has significantly reduced its role in financing health care in response to budgetary pressures. Due to cuts in Medicaid funding from 1975 to 1983, the portion of low

Income Americans covered under that program fell from 63% to 46%. In 1981, categorical health programs such as TB control, rural health initiatives, etc., were "block granted" and then transferred to the States with reduced funding. And now, Medicare faces the Gramm-Rudmann budget reductions.

Every informed analyst predicts even further federal reductions in health programs for the foreseeable future. Therefore, new federal funding for resolution of the uncompensated care problem appears unlikely. In fact, William Roper, President Reagan's Health Policy Advisor and Director of HCFA, recently stated "The answer to uncompensated care will have to come from the private sector, States, and localities."

California health programs, in 1982, were likewise cutback for the purpose of balancing the State budget. As a result, programs such as Medi-Cal were reduced as much as 20 percent. Also in 1982, the State transferred responsibility for MIAs to the counties, and simultaneously reduced their funding by 25 percent. These cuts have never been fully restored. The low fees paid to physicians by Medi-Cal and county programs virtually forces many patients to seek care in the more costly hospital emergency room or outpatient clinic.

Counties, similarly, have insufficient funds for the care of their indigents. In a move to prioritize scarce health dollars some counties chose to quit paying for emergency services rendered to their indigent patients in private hospitals. Often these patients arrive in the emergency room following an injury or illness and require extensive crisis surgical and other emergency medical care in order to be stabilized. The treating physician and the hospital must absorb the entire cost if the county refuses to pay. It is not uncommon for a single such incident to cost several hundred thousand dollars. Further, neither hospital nor physicians can shift these costs to other payors because almost all care is provided at a negotiated fixed price. This emergency care is emotionally anguishing to the physician and usually rendered at the expense of the doctor's normal patient load. As a result, physicians are beginning to remove their names from hospital "on-call" lists in order to reduce their exposure to this extremely expensive and stressful source of uncompensated care. If this trend continues, private hospitals will have to close or downgrade their emergency services thereby reducing patient access to emergency care.

Lower government funding has two overall effects. First, eligibility for coverage under government programs is constricted. The newly ineligible population is almost all poor or near poor, and thus, unlikely to be able to afford private insurance. Consequently, most of these people will enter the pool of the uninsured; those most likely to generate uncompensated care. Second, reduced government funding also translates into lower provider reimbursement fees. Underpayment also causes uncompensated care. As noted earlier, the reimbursement rates

offered by Medi-Cal and other government programs barely cover out-of-pocket costs. These low rates have a chilling effect on the number of providers willing to accept beneficiaries in an ever-competitive marketplace. As a result, even covered beneficiaries can have a reduced access to care.

B. "COMPETITIVE" INSURANCE PRODUCTS

Also exacerbating the problems of uncompensated care is the recent "competition" in the health insurance industry. In response to market forces, insurers are now focusing more on actuarial soundness and cost containment in designing their policies. These market forces have added to the uncompensated care problem in two ways.

First, more people are entering the ranks of the "uninsured," the population most likely to generate uncompensated care. As insurers attempt to more closely align costs to premiums, the high risk groups such as those with preexisting medical conditions or the elderly, become statistically undesirable. These patients may be unable to find coverage at affordable premiums, or not at all. Hence, they too are entering the ranks of the uninsured and generating significant uncompensated care.

"Costs" are a potent force in the marketplace. In order to keep costs down, some "self-insured" employers have restricted the number of benefits in their policy. Their beneficiaries are, therefore, "underinsured", because a needed service may not be covered. A beneficiary who receives care for an uncovered service is effectively "uninsured" for that service, and thus, more likely to cause uncompensated care.

Underinsurance is also a problem with "individual" policies offered by insurance carriers. Usually, benefits are kept low to keep these policies affordable. Individual policies constitute about 22% of the private insurance market. Individual policy beneficiaries are, similarly, often uninsured for some needed benefit, and, thus more likely to generate uncompensated care.

Each of the above problems will be detailed in the following sections discussing the uninsured and the underinsured. Suffice it to say for now that the private insurance industry is leaving more and more people uncovered which, consequently, gives rise to more uncompensated care.

The second major effect of competition in the insurance market place has been the loss of the providers ability to "cost shift". Providers traditionally "shifted" or "spread" the cost of their nonpaying patients among those patients who could pay. Each paying patient's bill was raised a fraction in order to cover the costs of the patient who could not pay. Since the third party payors paid for most of the bill, the cost was indirectly spread among the general population through higher premiums or taxes. New cost containment payment methods i.e., prospective payment systems, preferred provider organizations, diagnostic related groups, health maintenance organizations,

utilization review committees, etc., have reduced reimbursements to providers. Third-party payors, thereby limit provider reimbursements to a fixed amount per service rendered. This amount does not include anything extra for uncompensated care. Thus, cost shifting is increasingly difficult for providers. A provider who is unable to cost shift must absorb the entire cost of the uncompensated care they render. This matter is discussed further in the section on "Effect on Physicians," but for now it is important to recognize that the competitive insurance market is precluding the provider's ability to "cost shift".

The following three sections discuss the uninsured and the underinsured in the private insurance industry. Remember that the problems caused by the competitive insurance market work in combination with the problems caused by the shrinking government funding.

C. THE UNINSURED

The number of Americans without any health insurance increased by 20% from 1979 to 1984 according to unpublished census data. The population generating uncompensated care is closely related to the uninsured.

The "Uninsured" constitute about 15.3% of the U.S. population at any given time. Approximately 9% of those were uninsured all year. The remaining 6.3% averages out from another 9.4% of the population that had insurance only part of the year. Hence, 18.4% of the U.S. population was uninsured for at least part of the year.

1. Work-related Coverage

Currently, 78% of the private insurance market is purchased through the less expensive group plans, usually as a fringe benefit of employment. However, many people are unable to obtain insurance through their employment. These include:

- a. The employer excluded. "Under existing federal tax laws, firms are allowed to exclude from employer-provided health insurance eligibility persons under 25 years of age, part-time and seasonal workers, non-resident aliens, workers with less than 3 years of service, and employees covered by an employee agreement with an employer." (Mulstein pg. 216 Attachment 1).
- b. The temporarily unemployed generally lose benefits following termination. A few states have continuation requirements, but few workers are aware of this option, others can't afford the entire cost of the policy. About 33% of all unemployed workers are without any coverage.
- c. Self employed workers, especially trade workers, rarely have access to group plans. Many can not, or will not, purchase the more expensive individual plans. Approximately 23% of all self-employed are uninsured.

- d. Insurance is often unavailable from employers, especially those with less than 26 employees or those who hire large numbers of low-wage workers.
- e. Individuals with pre-existing medical conditions. If employment based coverage is even offered, the pre-existing condition itself is usually excluded. Individual policies are very expensive or totally unavailable due to the high actuarial risk.
- f. Persons who change jobs frequently are left uncovered during pre-coverage waiting periods under the new employer.

Unavailability or termination of employer-based coverage doesn't only affect the worker. Generally, the worker's spouse and dependents are left uncovered. Three-fourths of all citizens without insurance are part-time or full-time workers and their dependents.

2. Individual Policies.

People who are unable to obtain employment-based coverage may seek an individual policy. Individual policies are 22% of the private insurance market. However, due to the higher number of adverse risks enrolled, these policies are usually very expensive. Many people are simply priced out of the market.

3. Demographics of the Uninsured.

Important demographic information about the uninsured in the U.S., includes income and age. In 1982, 35% of the uninsured had incomes below the poverty level (\$9,000 for a family of four). Another 29% had incomes between \$9,000-18,000. Another 16% were between \$18,000-\$27,000, and 20% were over \$27,000. Data regarding age indicate that the uninsured are very young, 52.4% being under 24 years old. The young may not perceive themselves to be at risk of illness; and, income levels affect consumption priorities. These factors influence an individual's choice of whether or not to purchase coverage.

B. THE UNDERINSURED

The majority of uncompensated care may be traced to the absence of insurance, but it may also arise from inadequate insurance coverage, called "Underinsurance". Underinsurance occurs when policy benefits are inadequate to cover health needs. Inadequate benefits are discussed in the next section. However, underinsurance can also exist when a patient has some insurance, but the extent of coverage is inadequate to keep total patient "out-of-pocket" expenses at an affordable level; especially in the event of a catastrophic illness. Frequently a patient is unable to pay his or her share following a major illness.

Some insurance contracts put a lifetime or per-episode limit on the amount they will pay, for example, \$250,000 or \$500,000. If the total bill exceeds this amount, due to a catastrophic event, the patient will

be held liable for the remainder, even if her or she is not able to pay. Catastrophic illnesses represent about 2% of uncompensated care cases, but constitute about 35% of uncompensated care costs for hospitals.

E. ADEQUACY OF BENEFITS

The third major concern about private insurance regards the "adequacy of benefits", a topic which is often considered as a subset of underinsurance. The "adequacy of benefits" relates to the types of services which are covered under a policy, e.g., hospital inpatient care, outpatient services, home health care, preventive services, mental health, substance abuse, etc. Frequently an insured person discovers, too late, that they require a service which the policy does not cover. For example, someone may think of themselves as fully-insured, but in fact they are covered only for facility-related expenses and not for physician-office care. Physician office visits are not covered under 12% of employment related group insurance plans. (Mulstein 218).

The group most likely to have inadequate benefit coverage in their policies are the individual policyholders. In order to keep individual policies affordable, some insurers have simply kept the benefits covered at relatively low level. Low-income, unemployed, and self-employed individuals tend to be more likely to have individual insurance plans.

Inadequate benefits may also be a problem in some group plans. Of special concern are the "self-insured" employer benefit plans. Unfortunately, many of these self-insured employers have chosen to provide an inadequate level of health benefits in order to keep their costs down. The Legislature cannot mandate the self-insureds to provide a minimum floor of benefits because these plans are exempt from state regulation under the federal ERISA pre-emption. Self-insured employer plans have captured more than half of the California insurance market since 1975 and continue to grow.

II. EFFECT ON PHYSICIANS

Physicians have traditionally rendered generous amounts of uncompensated care. A 1982 AMA survey indicated that total practice billings of the responding physicians were reduced, on average, by 9.1% for "charity" care, defined as free or reduced care, another 6.3% declared "bad debt." (Ohsfeldt, Attachment 2) There is little doubt that physicians will continue to render significant amounts of uncompensated care, but certainly each individual has a limit.

As explained earlier, providers are increasingly unable to "cost shift" and are thus forced to absorb the cost of the uncompensated care they render. Simultaneously, providers are experiencing greater amounts of uncompensated care due to the government cutbacks and the growing legions of uninsured and underinsured. As each provider becomes

overburdened by uncompensated care, that provider tends to "transfer" or "dump" some of the responsible patients onto other providers, generally to the public facilities. Facts already show that for-profit hospitals "skim" off the full pay patients and dump their uncompensating and undercompensated patients onto county facilities. The patients most likely to be dumped are the: indigent, uninsured, underinsured, "self-paying", Medi-Cal and Medicare patients.

Current economic and policy factors also cause the burden of uncompensated care to be distributed unequally onto only a few providers. For example, those physicians in close proximity to low income areas are generally exposed to much more uncompensated care. Obviously physicians who serve, as a larger percentage of their patient mix those clients who cannot pay or underpay, shoulder most of the uncompensated care burden. Said another way, the doctors who primarily serve the poor and near-poor will be the ones punished most under the current policy.

After awhile overburdened physicians will limit their exposure to uncompensated care. Initially, they will limit access to non-paying and underpaying patients. Eventually, they will move to a less burdensome economic environment. The specter is raised of poor and low income areas eventually being denuded of physicians. Ironically, this trend countermands the long-standing public policy of promoting services for, and getting physicians into, underserved areas.

In summary, private physicians are now increasingly absorbing the burden of uncompensated care which is being shed by the government and the private insurance industry. Unfortunately, the burden falls unequally on just a few physicians, primarily those who serve the low-income.

III. EFFECT ON THE PATIENTS

As increasing numbers of providers become disproportionately burdened, they will move to limit their exposure to uncompensated care. Access to private health care will diminish incrementally for many low-income patients; primarily Medi-Cal, Medicare, indigent, "self-paying" uninsured, and underinsured patients. Care will gravitate to county facilities, often to the more expensive emergency room.

Facts already show that many for-profit hospitals "skim" off full-pay patients and "dump" their uncompensating patients onto county facilities. Doctors currently provide a large amount of uncompensated care. If the doctors who are disproportionately burdened begin to transfer patients, in increasing numbers, to county facilities, can the county facilities handle the load, especially in the light of continuing cutbacks?

A policy of continuing cutbacks, along with an increasing propensity to "dump", portends the return of a sharply divided "two-tiered" system of health care: One for those who can pay fully, and another in county facilities for those who can't. In fact, President Reagan's health

policy advisors already suggest that "society should be concerned that the poor receive health care services of adequate quality," and openly suggest a multi-tiered system. (Roper)

IV. SUMMARY

The effect of today's trends is that more and more people are entering the roles of persons who are likely to generate uncompensated care. More people are without insurance or have inadequate insurance. Government is paying for fewer people. Providers who treat these people are no longer able to "spread" or "shift" the costs of uncompensated care onto their other patients.

Consequently, in this environment all of the parties involved in health care transactions have the propensity to "skim off" those patients who can pay fully and "dump" those who can't. The short term consequences of this trend is a reduced access to care for patients who can not pay or who underpay. The long term effect portends the return of a sharply divided "two-tiered" health care system. One for those who have adequate income and insurance. Another for those who are: uninsured, underinsured, a Medi-Cal beneficiary, an indigent, a "self-pay" patient, or anyone else who can not pay fully.

V. CMA POLICY DEVELOPMENT

The California Medical Association like other interested organizations, has been grappling with the potential solutions to the complicated matter of uncompensated care. However, the CMA is in the process of evaluating various general policy considerations, including the following:

- Consideration #1: No one should be denied needed health care due to an inability to pay.
- Consideration #2: Everyone should receive the best quality health care, a deliberately designed "two-tiered" system should not be permitted.
- Consideration #3: Priority should be placed on utilizing the private sector to reduce the problem of uncompensated care. A government funded program should be a last resort.
- Consideration #4: Costs of those who cannot pay for their needed medical care should be spread among the general population in the form of higher insurance premiums or taxes.
- Consideration #5: Many patients have the ability to pay their co-payments, deductibles, and "self-pay" bills, but choose not to do so. Collection from these patients should be enhanced in order to maintain equity in the system as well as bring in needed revenue.

THESE CONSIDERATIONS ARE NOT CMA POLICY. THEY ARE MERELY A STARTING PLACE FOR CMA DELIBERATION.

VI. ALTERNATIVES FOR COVERING THE COST OF UNCOMPENSATED CARE UNDER DELIBERATION BY THE CMA

Current public policy is transferring the cost of uncompensated care onto providers, especially those who serve the poor and near poor. As current trends continue, how should the costs of those who can't pay be allocated among insurers, patients, providers, and government? The CMA is considering the following alternatives.

A. Insurance

Traditionally, insurance companies passed on the cost of uncompensated care to the general population in the form of higher premiums. Premiums were raised to cover the higher payments caused by the provider cost-shift. This manner of paying for uncompensated care has some attractive features: It does not appear on the government's balance sheets and no bureaucracy is created to administer the program.

At present, the cost-spreading function of insurers cannot be utilized because the federal ERISA preemption exempts self-insured employers from state insurance mandates. If ERISA did not exempt the self-insureds, many insurance-based solutions to paying for uncompensated care would be available. For example, the CMA has long supported the concept of mandating an all-payer risk pool. Under this proposal, people who are poor risks due to a pre-existing medical condition, and who cannot otherwise get insurance, would be able to purchase coverage from the risk pool. All health insurers would be required to participate in the pool and offset losses in proportion to the amount of business each does in the state. The costs of the risk pool would be indirectly spread to the entire population without an expensive government bureaucracy or oppressive regulations. There would be no burden on the insurers because they merely pass on the costs to the insureds.

CMA may consider expanding the risk pool concept to cover other uninsured groups, such as the low income workers who are unable to obtain insurance through their employer and can't afford an individual policy. A policy could be sold by the pool to these average risk workers at a premium below individual policy rates. Again, there will be no burden on the insurers because they could compensate for the added cost through slightly higher premiums for everyone.

Other mandates might be considered in order to expand coverage and reduce the possibility of uncompensated care. Such mandates include:

*That a specified benefits package be included in all policies, such as catastrophic coverage, preventive care for children, etc.,

*That all insurers offer coverage for the premium indigent, especially low-income workers, through a sliding fee premium, based on income and perhaps with government funded premium assistance or vouchers.

*That insurance reimbursement rates include an extra amount for uncompensated care.

*That employers offer or arrange for group coverage for all their employees.

*That all insuring entities participate in a statewide risk pool, operated primarily for the medically uninsurables and perhaps others.

ALTERNATIVE #1: Should CMA should sponsor a state resolution which asks the federal government to amend ERISA so that the Legislature can enforce state insurance mandates on the self-insured employers?

ALTERNATIVE #2: If ERISA is amended, should CMA consider sponsoring legislation imposing a certain mandates on the insurance industry to expand coverage?

ALTERNATIVE #3: Assuming ERISA is amended, should CMA sponsor legislation requiring all insuring entities to pay for uncompensated care either in proportion to the business they do in the state or through adjusted reimbursement rates?

B. Patients

As insurers and government shed their fair share of uncompensated care, poorer patients carry the burden of uncompensated care in the form of reduced access and denied services. The Reagan Administration suggests that an inadequate quality of care may be their fate i.e. a two-tiered health care system.

ALTERNATIVE #4: Should CMA continue to oppose development of a two-tiered system of health care?

On the other hand, some patients have the ability to pay their "self pay", copayment, and deductible bills, but choose not to do so. Nevertheless, most physicians have continued to treat these patients, preferring to maintain a good physician-patient relationship.

ALTERNATIVE #5: Should CMA encourage doctors to expand collection efforts from their patients with the ability to pay? This includes use of collection agencies and the legal system. County medical societies could also be encouraged to sponsor collection agencies.

A patient's ability to pay his bill is facilitated by insurance coverage. However, many people choose to not buy insurance, even though they could afford it. In 1982, 36% of the uninsured had family incomes over \$18,000 per year. 20% of the uninsured had family incomes over \$27,000 a year. These facts militate in favor of a policy of mandated insurance coverage for wealthier population groups.

ALTERNATIVE #6: Should CMA sponsor a bill which mandates that heads of households earning over \$20,000 annually purchase health insurance?

This measure should be contingent on coverage being available at no more 150% average group rate.

Most of the patients who cause uncompensated care in hospitals are young adults and their children. Young adults may choose to forego insurance due to a low perceived health risk, even if they are not low income. Additionally, many young adults who are low-income may mature into higher income brackets.

ALTERNATIVE #7: Should CMA investigate the possibilities of improving county, and perhaps private, facilities collections? Potential remedies could include: 1) development of an expedited process for obtaining judgments for uncompensated care, 2) requiring tax authorities to notify a facility with a judgment when the patient's household annual income exceeds \$20,000 per year, 3) a process to facilitate attachment of wages, and 4) extending the statute of limitations to these debts.

C. Government

Even if every private sector option was exercised, it is still conceivable that a few people would be left unsponsored.

ALTERNATIVE #8: Should CMA support expansion of existing funding for traditional government programs, such as Medi-Cal etc., to pay for all those who are truly unable to pay?

ALTERNATIVE #9: Should CMA support supporting legislation, such as AB 600, calling for a new revenue pool to be collected to offset premium costs for the medically uninsurables as well as the low-income who do not qualify for traditional programs and who are unable to afford private coverage? The coverage could, additionally, be made available on a sliding fee basis.

ALTERNATIVE #10: Should CMA investigate the possibility of legislation which would assure, through tax incentives or penalties, that employers offer coverage to all of their employees?

ALTERNATIVE #11: Assuming ERISA is amended, should CMA support government-financed incentives, through vouchers or subsidies, for insurers to develop new insurance products in order to meet the needs of those uninsured unable to otherwise afford coverage?

D. Providers

As noted throughout this document, the burden of uncompensated care is falling onto providers. Further, the burden is falling onto only a few providers, primarily those who serve the low-income.

ALTERNATIVE #12: Absent a comprehensive solution to the uncompensated care problem, should CMA consider supporting: a) a bill, such as AB 2004 (Bronzan), which would redistribute the burden equitably among facilities, or b) a bill which redistributes the burden among all providers?

If new Insurance products are created by the private sector (perhaps with government subsidy) for those currently uninsured, cost-containment could be a problem.

ALTERNATIVE #13: Should CMA consider whether the current cost-containment trends of the private Insurance Industry are adequate to restrain inflation, or whether providers should offer discounts for the low income newly-insured groups?

Again, CMA policy is currently being developed. The alternative considerations above will most likely be substantially revised and they are only a starting point to develop the CMA position. CMA will submit recommendations to the Legislature as soon as they become available. Thank you for allowing us to comment on the uncompensated care problem in California.

Presentation before the
California Senate Symposium on
Uncompensated Health Care and Access for
the Unsponsored and Indigent Patient
by

Jane Tilly

American Association of Retired Persons

June 20, 1986

On behalf of the American Association of Retired Persons I welcome the opportunity to discuss indigent and uncompensated care with you. We also commend you for holding a conference on this issue because caring for the uninsured and underinsured is one of the biggest challenges that society faces today.

The Association, at both the federal and state levels, is concerned about the uninsured, underinsured, and the effects of uncompensated care on the health care system. These problems are troubling because of the stress they place on the poor and on charity care providers.

Persons without adequate financial protection suffer because of a lack of access to needed services. Many of the uninsured who could benefit from preventive care forego it because they cannot afford to pay their medical bills. Consequently, the uninsured use about half the health services that the insured population does.

Physicians, hospitals, and other providers often turn away those who cannot pay, even during emergencies. Many states have hospitals that routinely dump emergency patients on public facilities without even stabilizing the patients. People have died or been seriously injured because of these practices.

One group that merits attention is the working poor. About half of the uninsured are employed all or part of the year. Many of these people are in low wage jobs that do not offer good health benefits.

Thus medical costs can be enough to bankrupt them.

In addition, the underinsured -- those whose protection is inadequate, often do not get the care they need. In particular the poor elderly have trouble because of the gaps in Medicare coverage. Beneficiaries must pay a high hospital deductible as well as 20% coinsurance and a deductible for physician services. Physicians may also charge beneficiaries for the bills that Medicare will not pay. Finally, Medicare does not pay for much of an elderly person's long-term care needs. Given these gaps the program covers less than half of the elderly's bills.

People who cannot afford Medicare's deductibles and coinsurance often do not seek medical care when they need it and only do so in emergencies. Thus despite Medicare many elderly are inadequately insured.

Providers who deliver much of the free care to persons without adequate financing are at a great disadvantage in an increasingly competitive health care marketplace. Hospitals must raise their prices to paying patients to cover the cost of charity care. Then when group purchasers seek out low cost providers, public hospitals and others with a commitment to the poor lose out because of their high prices. Private paying patients are then directed to lower cost hospitals leaving charity care providers with an even heavier burden.

These problems point out that the health care system is not functioning for vulnerable portions of our population. Access to care and the support of public hospitals are the major issues that the state and federal governments must deal with.

AARP has always supported governmental efforts to deal with the health care financing problems of vulnerable groups. We were and are active in advocating for Medicare and Medicaid. These two programs provide what support there is for the aged and the poor.

Unfortunately these programs, which were never adequate, have eroded over time. Medicare now pays only 45% of the elderly's health care bill and Medicaid only serves half of the poor population. The question is "What can the states do to deal with these problems, particularly those of the uninsured and underinsured poor?"

There is no ideal method of addressing the indigent care problem because the situation differs in every state. However, a good goal for the states is to maximize state dollars and provide for the most efficient delivery of care possible. California should consider:

1. Using the Medi-Cal program to the extent feasible because each dollar the state puts in generates one dollar of federal matching funds. California already offers most of the Medicaid options possible. However, it could cover a larger portion of the uninsured population with higher eligibility levels.

The state also might consider financing more care for medically indigent adults. Several studies have shown that this population has suffered adverse health outcomes, including death, most likely due to reduced access to care.

2. Increasing funding for programs that provide preventive and primary care services. Programs for pregnant women and children are especially valuable from a humanitarian and an economic view point. For example, prenatal care can save lives, prevent deformities, and save money over the lifetime of a patient. Since much of charity care costs relate to these populations, preventive and primary care services can be especially effective in forestalling health care problems.

3. Relieving hospitals that have excessive charity care burdens. This can be accomplished through revenue pools. A state could tax facilities' net revenues and use the money to help over-burdened hospitals with their charity care costs. An alternative is for the state to use some of the money to finance Medicaid or other health care programs for the poor. Florida, New York, and Massachusetts have used this kind of arrangement.

California could consider another type of revenue pool. This is where hospitals either provide a minimum amount of charity care (e.g. 6% of gross revenue) or contribute to a pool of funds. The pool would be used to help hospitals that provide more than the minimum amount of

charity care. The advantage of this mechanism is that all hospitals in a competitive system such as California's would have approximately the same charity care burden.

There are a number of advantages to using hospital revenue. However, this source of funding is not inexhaustible and hospitals should not be made to bear the brunt of indigent care costs.

4. Preventing the dumping of patients who need emergency care. Two states, Texas and South Carolina, have passed anti-dumping laws. These laws require hospitals to stabilize emergency patients and notify the receiving hospital prior to a transfer. I understand that California is considering similar legislation. The advantages of such a law are more humane treatment of patients and a reduction in public hospitals' burdens.

The Association's State Legislative Committees have supported increased Medicaid funding and primary care programs in any number of states, an anti-dumping statute in Texas, and revenue pooling arrangements in Florida, New York and other states. Volunteers from AARP's State Legislative Committee in California stand ready to work with you on possible solutions to the state's problems with indigent and uncompensated care.

We also would like to offer you access to some work that we have commissioned from Larry Bartlett of Health Systems

Research. Mr. Bartlett has completed state specific descriptions of indigent care programs and is finishing up an excellent pro/con paper about various methods of caring for the uninsured.

In conclusion, the Association has a keen interest in ensuring that persons of all ages have access to the health care services that they need. No one in a society such as ours should be turned away because they cannot pay a bill. We are committed to working with all parties who wish to make an effort to solve the access problems that many vulnerable groups in our society face.

STATE FINANCING OF INDIGENT HEALTH CARE:

Promise and Problems

National Health Law Program

I. INTRODUCTION

Approximately 13% of the population shares a severe health problem -- medical indigency.¹ This condition has worsened in recent years as increasing numbers of hospitals refuse to provide treatment, and state policy-makers are searching for a cure. Over 30 states have established task forces to study the problem of medical indigency.²

The most widely discussed financing mechanisms to address this issue involve revenue pools, insurance for the uninsured and innovative state/local programs. This article will explore the experience of those bellweather states using these financing mechanisms and suggest advocacy tools for enforcing patients rights under these new programs.

II. REVENUE POOLING

To date, revenue pooling has been limited to hospital payments. Assessments are collected from hospitals or insurers and distributed to providers rendering the greatest amounts of indigent care. Revenue pools attempt to "level the playing field" by giving those hospitals which bear the inequitable burden of providing indigent care a more predictable source of reimbursement for that care. Theoretically, the need to shift costs onto private payers or to rely upon ever-shrinking public grants is decreased. If the system functions properly, the ability to compete for paying customers and equity financiers is enhanced, and low income access to care is maintained or improved.

Revenue pooling legislation is under consideration in about half

the states. Five states - New York, Massachusetts, Florida, West Virginia, and South Carolina - already operate revenue pools. In the spring of 1986, the National Health Law Program surveyed these states to evaluate their systems. While similar in purpose, these pools vary dramatically in design, some serving our clients better than others.

A. How the Pools Function

1. New York

Since 1983, New York has used revenue pools to fund indigent care. Currently, there are three separate pools. Two operate regionally: the bad debt/charity care pool and the financially distressed hospital pool. The third pool is a statewide charity care/bad debt pool.³

The two regional pools are funded by a percentage add-on to the rates paid by third party payers (private insurers and Medicaid) and self-pay patients. The bad debt/charity care pools are allocated to major public hospitals on the basis of reimbursable costs and to all other hospitals on the basis of bad debt and charity care costs. The financially distressed hospital pools are distributed to qualifying hospitals to cover additional bad debt/charity care costs and to help secure financing for capital improvements. Public hospitals are not eligible to receive funds from this pool; theoretically, their additional uncompensated care costs are already covered by public grants and subsidies.

The statewide pool was created, in part, to meet the balance of hospitals' uncompensated care needs.⁴ To fund this pool, voluntary non-profit and proprietary hospitals would be assessed a certain percentage of their actual Medicare revenues. However, a recent

decision, Arnot Ogden Memorial Hosp. v. Axelrod,⁵ prohibited the use of Medicare dollars from plaintiff hospital to fund the pool. According to the court, "the Medicare legislation explicitly provides that there will be no cross-subsidization in determining reasonable [Medicare] costs."⁶ The decision, which is currently on appeal, also found that New York was preempted from reallocating Medicare funds using a state formula, because Congress has already mandated adjustments to Medicare payments for hospitals serving disproportionate numbers of indigent patients.⁷

2. Massachusetts

Massachusetts has a single statewide pool.⁸ As in New York, the pool is funded by insurers. In Massachusetts, the Rate Setting Commission adds a uniform surcharge (8-9%) to the prices charged by all non-governmental third party payers. Hospitals with free care/bad debt costs less than the surcharge pay the difference into the pool. Hospitals whose free care/bad debt costs are higher than the surcharge bill the pool directly for the difference.

In both New York and Massachusetts, the amount of funds that can be placed into the pools is constrained by the federal Employee Retirement Income Security Act of 1974 (ERISA).⁹ Although not a model of legislative drafting, ERISA appears to preempt all state laws which regulate "employee welfare benefit plans."¹⁰ Health insurance programs are considered to be employee welfare benefit plans. Courts have consistently ruled that when employers self-insure or self-fund, they are establishing employee welfare benefit plans which are exempt from state regulation -- even though these plans provide the same coverage as those purchased from a private, commercial insurer.¹¹ Thus, neither

Massachusetts nor New York can collect surcharges directly from self-insured plans. And, over time, funding the pools through surcharges on private insurers could lead increasing numbers of employers to self-insure, thus causing pool revenues to shrink.

3. Florida

Florida has designed a revenue pool that avoids the ERISA issue altogether. In 1984, the Public Medicaid Assistance Trust Fund was created, and Florida became the first state to finance indigent care through direct assessments on hospitals rather than commercial hospital insurers.¹² Hospitals in the state are annually assessed a flat percentage of their net operating revenues (1.5% beginning July 1, 1986). The state adds an additional annual contribution of \$20 million from general revenues. The majority of these amounts are, in turn, placed with the state Medicaid agency, and matching federal Medicaid dollars are obtained.

This pooling of hospital, state, and federal dollars has allowed Florida to expand its Medicaid program to cover previously ineligible groups. Medicaid coverage has been extended to financially eligible children under 21 in intact families and to unemployed parents and their children. Beginning July 1986, funds will also be used to finance a medically needy program that covers all groups except the institutionalized. In contrast to New York's emphasis upon reimbursing inpatient hospital care, Florida has, as a priority, use of the funds for noninstitutional and primary care. For example, in 1985, the legislature authorized \$10 million from the pool for primary care. As a result, \$9.5 million was distributed to various county public health units to fund primary care projects they had proposed.

4. West Virginia

West Virginia's indigent care fund resembles Florida's. The West Virginia Healthcare Cost Review Authority is authorized to assess all non-state hospitals an aggregate amount of three million dollars.¹³ Each hospital's assessment is based on a three-year average of its excess of revenue over expenses, weighted to account for the ratio of total Medicaid revenue to total health service revenue. (A three year average is used because reduced Medicaid utilization in the state had caused some hospitals to lose money that had not lost money before.) Hospitals experiencing an operating deficit do not pay into the pool. The state contributes an additional amount from general revenues. All moneys paid into the indigent care fund are used to supplement the state's Medicaid program so that federal matching funds can be obtained.

At its inception in 1985, the West Virginia pool was envisioned as a one year program to pay off a backlog of Medicaid payments owed to hospitals.¹⁴ Consistent with legislative authorization, however, the Cost Review Authority also increased limits on Medicaid inpatient days from twenty to sixty days and increased payments for emergency room and some outpatient services. The indigent care fund was authorized for another year in 1986. New revenues will also be used to expand maternal and child health services.

5. South Carolina

With implementation of the Medically Indigent Assistance Fund on January 1, 1986, South Carolina became the most recent state to embrace the revenue pooling concept.¹⁵ Hospitals are assessed an amount based upon the prior year's ratio of net patient revenue to gross patient

revenue multiplied by the total number of patient days. In a unique financing feature, matching county contributions are collected using a formula that weighs each county's property values, per capita income, and net taxable sales. In the future, the county contribution will be based on the claims experience against the fund by county residents.

In another unique feature, the South Carolina legislation defines "medically indigent" persons who are eligible to have their care reimbursed by the pool. Persons who fall below the federal poverty level and meet other resource tests regarding real property are eligible for free care. Those with incomes from 100-200% of the federal poverty level are eligible for partial payment of bills based on a sliding fee scale.

Funds from the pool are distributed directly to hospitals. Each month, hospitals send their charity bills to the county. The county funnels these bills to the state, and the state ultimately reimburses hospitals for their charity care at a Medicaid DRG rate - a rate that has not yet been applied to the Medicaid program.

B. Performance of the Pools

The jury is still out on how successful the pools will be. To date, advocates report that hospitals have not viewed revenue pools as a green light to care for dramatically increased numbers of the uninsured. However, the pools do seem to help hospitals maintain previous levels of indigent care. Two problems that plague revenue pools are the lack of accountability and outreach.

1. Accountability

Accountability issues arise primarily in those states where the pools reimburse hospitals for their unmet bad debt and/or charity care

needs. Advocates in these states complained that funds are distributed to hospitals on the basis of the hospitals' own unverified estimates of bad debt and charity care.

In New York, for example, there are no guidelines to insure that hospitals are uniformly and consistently determining who is eligible to receive charity care. There are anecdotal stories of hospital abuse because of this lack of accountability: One Hill-Burton facility refuses to accept Medicaid patients, sending them instead to the public hospital or writing them off to Hill-Burton or the charity care pool. This practice continues even though revenue pool provisions clearly prohibit the use of pool funds until all other third party coverage has been exhausted.

Although the New York statute requires the Department of Health to identify "appropriate and reasonable standards for the development of acceptable collections procedures," it has not done so.¹⁶ To date, the Department has merely considered having hospitals submit their collection policies for review and approval. A consumer-based proposal to dedicate money from the pools to labor and delivery care and condition distribution upon the hospital's development of a prenatal outreach and accountability plan has not been accepted.¹⁷

By contrast, Massachusetts has recently adopted a uniform set of hospital collection regulations.¹⁸ Persons with incomes less than or equal to the federal poverty level must be given free care, if treated. At the hospital's discretion, persons with incomes between 100-200% of the federal poverty level can also qualify for free care. For paying patients whose incomes are less than or equal to 200% of the federal poverty level, the execution of a lien against the home and car is pro-

hibited, as is the use of pre-admission or pre-payment deposits. (Nor may emergency patients be subject to pre-treatment deposits.) Hospitals' collection policies must be filed with the Rate Setting Commission. Finally, the regulations require hospitals to post signs in admitting areas that inform patients of the availability of free care and where to apply for the care. If a patient indicates an inability to pay, the hospital must give individual notice of the availability of free care.

2. Insuring Accountability Through Litigation

The revenue pooling statutes in most of the states detail specific activities that the administering agency must undertake. Often, implementation of these requisites will heighten provider accountability. For example, the agency may be required to promulgate standards for hospital collection procedures, to define who qualifies for free care, and/or to develop rules that require providers to submit uniform data regarding their indigent care. Advocates should scan their statutes for such mandates. When the agency is failing to implement provisions or when the agency has put rules in place without adhering to the state administrative procedure act's rule-making process, an administrative or judicial action may be filed. Generally, administrative actions take the form of petitions for administrative rule-making and, in most states, may be filed by any interested person. Filing a petition for administrative rule-making is not usually a prerequisite to judicial action. Thus, affected persons can subsequently or, in the alternative, file a judicial writ of mandate asking the court to compel the agency to adhere to the requirements of the statute. Relief is dependent, of course, upon state statutes and.

case law regarding mandatory administrative actions and proceedings for rule adoption and, therefore, will not be discussed here.¹⁹

Advocates can also attack the accountability problem by asserting reimbursement from the revenue pool as an affirmative defense in a hospital collection action. All states' pooling provisions require hospitals to submit their charity care/bad debt claims to the administrative agency within a certain period of time, usually one to three months. Once the bill has been submitted, the hospital receives payment from the pool. Hospitals that also pursue collection from the indigent person are improperly attempting to obtain double payment for the same service. Where the hospital has not sought reimbursement from the pool, the administrative agency can be joined in the action on the theory that the obligation to pay the debt rests with the agency.

Accountability can be further protected by tying revenue pool reimbursement to the community service obligation of those hospitals that received Hill-Burton construction funds.²⁰ The Hill-Burton community service obligation lasts in perpetuity and requires grant facilities to make arrangement for reimbursement from "state and local governmental third-party payer programs that provide reimbursement for services at not less than actual cost."²¹ Revenue pools in all the states meet the requirements of this community service obligation. Thus, Hill-Burton facilities have an affirmative duty to take steps to ensure that admission to and services of the facility are available to persons who are reimbursed under these programs without discrimination on the basis of payment. Any facility that refuses to admit persons whose care can be reimbursed by the revenue pool arguably violates its community service obligation; a complaint should be submitted to the

Department of Health and Human Services Office of Civil Rights which is the Hill-Burton community service enforcement unit. Ultimately, a judicial action may be filed.

3. Outreach

Outreach problems were mentioned by advocates in all of the revenue pooling states. Except for Massachusetts, none of the states requires hospitals to provide written or oral bilingual notices in hospital admitting areas regarding the availability of revenue pools to fund indigent care.

No state provides notices of the expanded Medicaid or free care assistance in social services offices. Florida experience perhaps best illustrates the failure of states to fully utilize their pool revenues due to lack of outreach. In that state, the enrollment of eligibles in the Medicaid expansion programs has been much lower than originally anticipated. Although estimates were that over 45,000 people would benefit from the expansion programs, only 1500 new recipients had enrolled by July 1985. Advocates note the paucity of outreach to affected groups and the lack of trained caseworkers as main contributors to the underutilization.²²

South Carolina advocates express similar fears that medically indigent persons will never know of the pool's existence and continue to avoid seeking needed services.²³ Advocates there can file petitions to require the administrative body to promulgate definitive outreach criteria. In addition, advocates may be able to require outreach from at least some state hospitals. According to the South Carolina statute, persons whose incomes fall below 200% of the federal poverty level are "medically indigent" for purposes of having their care cov-

ered by the pool. Facilities that received Hill-Burton grants have, as a part of their community service obligation, the affirmative duty to "take reasonable steps to assist the patient by notifying him/her of any governmental programs to which the patient may be eligible."²⁴ Facilities under the community service obligation, then, should have the affirmative duty to notify indigent persons of the existence of the revenue pool and to accept persons whose care can be reimbursed from the pool.

III. INSURANCE FOR THE UNINSURED

Americans are generally enthusiastic about insurance. Thus, the problems posed by the lack of insurance for the medically indigent appear to have a simple answer -- insure them. Yet, seldom do simple solutions exist to knotty problems, as states have found in studying ways to provide health insurance for their uninsured population. Most state efforts on behalf of the uninsured have been fragmented, addressing only subgroups of the uninsured and then inadequately.

A. Health Insurance for the Unemployed

Generally, states have focused on providing health care for the unemployed narrowly, through continuation and conversion policies.²⁵ Continuation policies permit persons whose health insurance policies have been terminated, usually because of job layoffs, to continue their policies for a specific period at the group rate, although they must now pay their employer's share of the premium as well as their own.

Conversion policies allow policy holders who purchased group health insurance at their place of employment to convert automatically to an individual policy. The conversion option becomes available at the end of the continuation period.

A provision in the recently enacted Congressional Omnibus Budget Reconciliation Act of 1986 (COBRA) now requires employers of at least 20 employees to provide group health insurance that includes continuation and conversion provisions.²⁶ Therefore, as a first step in any case involving health care needs of the recently unemployed, Legal Services attorneys should review the policy and termination events to make sure that the employee was properly given the opportunity to exercise the continuation and conversion options.

Congress and the states have searched for more comprehensive ways to provide access to health care for the newly unemployed, especially since the early 80's when recession-caused unemployment grew to 10.8%. In 1983 Congress considered and rejected several costly proposals to establish a block grant to the states to provide health insurance for the unemployed.

Although several states have studied the problem,²⁷ only Wisconsin has established a special state program for the unemployed uninsured. Wisconsin's original "ShareCare" program provided outpatient care and inpatient maternity care to the unemployed and their families in selected counties.²⁸ In October 1985, the program was replaced with "WisconCare" which provides limited inpatient and outpatient services in 18 counties with high unemployment. The program is funded by donations of free care from physicians and assessments on hospitals' private pay revenues.²⁹ Funds are distributed to community and migrant health clinics which, in turn, enroll uninsured persons who reside in the designated county, are unemployed or underemployed, and whose incomes are less than 150% of the federal poverty level. WisconCare is viewed as a short-term program until a statewide insurance for the

uninsured program can be implemented.

B. Mandatory Employment-Based Insurance for the Working Poor

Over three-quarters of the uninsured are workers and their families, many of whom do not meet Medicaid income or eligibility requirements. Finding a way to insure the working poor would have a huge impact on improving access for the uninsured.

In 1974, Hawaii adopted a mandatory employment-based insurance program. Hawaii's program requires employers to cover all employees who work at least 20 hours per week for four consecutive weeks; dependents are covered on a voluntary basis by employers for an extra premium. Employees' costs are limited to 1.5% of annual wages and employers must pay at least 50% of the premium. Workers earning less than 87% of the minimum wage and seasonal agricultural workers are exempt, and the state subsidizes the premium paid by firms with fewer than eight employees. It is estimated that only two percent of Hawaii's population is uninsured.³⁰

No state has followed Hawaii's lead in mandating employers to provide health insurance for their employees, primarily for three reasons: States are worried that health insurance costs will harm small businesses and make the state less attractive to industry; states fear increased employment costs of up to 33% for firms with low-wage workers will result in reduced wages or layoffs; states are concerned that mandatory employment based systems will cause more firms to self-insure and thus escape state regulation because of the ERISA preemption.

C. Health Insurance for the Uninsurable

Most private insurance companies will not extend coverage, or charge exorbitant premiums to persons with, pre-existing medical

conditions. The term "pre-existing condition" is usually defined in the insurance policy; advocates should check these provisions closely wherever an insurer refuses coverage on this basis. Any ambiguity in wording is to be construed in favor of the insured.³¹

Uninsured individuals who fall into this group are sometimes described as uninsurable. Nine states have established risk pools to provide coverage to persons who are uninsurable because of pre-existing medical conditions.³² Unfortunately, these plans are beyond the financial reach of the poor because of high premium and other cost-sharing requirements. Even with substantial cost-sharing, some states have found that risk pools do not generate enough income to be financially self-sufficient.³³

Generally, the risk pools require health insurers in the state to pool the risk of covering the uninsurable and subsidize the operating and administrative costs of the insurance. Insurers' assessments are based on their proportional premium income to all health insurers in the state. In some states, insurers obtain tax write-offs in return for their participation.

D. Health Insurance for the Catastrophically Ill

Catastrophic Health Insurance Programs (CHIPs) are designed as payers of last resort for persons facing the catastrophic cost of lengthy illnesses. Alaska and Rhode Island are the only two states which currently operate CHIPs. These programs are designed to serve persons with catastrophic expenses who have less than adequate private insurance coverage, and require sizeable deductibles and copayments. As with programs for the uninsurable, they have generally proved an inadequate mechanism to provide access to care for the uninsured poor.

States, despite large deductibles and copayments, have found providing health insurance for the catastrophically ill quite costly; Minnesota and Maine both discontinued their programs because of high costs.³⁴

A 1985 North Carolina study recommended a state-run CHIP targeted at the uninsured poor. The program, as proposed, would cover all medical costs once a sizable deductible -- 10% of income -- had been paid. The program would be the payer of last resort for those who don't qualify for the state's Medicaid program.³⁵

E. State Funded Insurance for the Uninsured

A few states have investigated the possibility of establishing a comprehensive state insurance program for the uninsured. Basically, these programs would purchase insurance for the uninsured but could vary in terms of the amount of state subsidy, premiums and cost sharing requirements, administration and reimbursement mechanisms.³⁶

In 1985, Wisconsin passed the State Health Insurance Program (SHIP), to replace existing, more limited programs.³⁷ The legislation establishes a Council on Health Care Coverage for the Uninsured to advise the Department of Health and Social Services. The Department, in designing SHIP, must follow a number of guidelines.³⁸ Unfortunately, given the barriers Wisconsin and other states must scale, implementing a state-wide program of insurance for the uninsured is difficult.

F. Barriers to Providing Insurance for the Uninsured

States have shied away from expanding insurance coverage for the uninsured because they have been unable, thus far, to effectively deal with four interrelated issues; financing, ERISA, loss of federal Medicaid funds, and fairness.

1. Financing

A state subsidized program to insure all or part of the uninsured population would, according to most estimates, be quite costly. For example, according to a North Carolina study, a state program which requires recipients to contribute up to 5 percent of income to premium costs, in addition to a 20 percent copayment on medical care, could cost the state \$104.9 million if all the state's uninsured poor had an opportunity to join,³⁹ while a Wisconsin study estimates state costs for a comprehensive program for the uninsured to be between \$70 to \$230 million a year.⁴⁰

Moreover, a state subsidized program for the uninsured would, it is feared, encourage employees to drop their employment-based program in favor of a better subsidized state package and employers to eliminate coverage for their employees. This possibility argues for state mandated employment-based coverage which in turn forces states to confront the problem of ERISA.

2. ERISA

As discussed above, with respect to revenue pools, the federal Employee Retirement Income Security Act preempts state laws from regulating employee welfare benefit plans. Thus, ERISA severely limits the ability of states to regulate health insurance benefits provided by self-insured or self-funded employers. (Hawaii was specifically exempted from ERISA requirements by Congress in 1982 so that its mandatory employment-based insurance program remains intact.⁴¹) Until COBRA legislation requiring even employers who self-insure to provide continuation and conversion policies, Congress had been unwilling to tinker with ERISA preemption of state laws regulating employee welfare benefit

plans. It should be noted, however, that COBRA does not change the federal preemption clause. Instead, Congress required employers, as a condition of receiving federal tax deductions, to include continuation and conversion options in their health insurance plans.⁴²

3. Loss of Federal Medicaid Funds

Any type of insurance program for the uninsured could result in a loss of federal Medicaid funds for the medically needy population; persons with state subsidized insurance could not spend down to qualify for Medicaid. This would result in a transfer of beneficiaries from the federal-state funded Medicaid program to a state-only funded program.

4. Fairness

Many of the state insurance programs include large cost-sharing requirements and address only one subgroup of the uninsured population. A program for the newly unemployed does not help the majority of uninsured, who are the working poor and their families. Nor does a catastrophic program provide assistance to most low-income uninsured individuals because of high deductibles and coinsurance. Similarly, risk pools for uninsurables are generally priced too high for the poor and near-poor uninsured population.

Despite these problems, states continue to investigate how to provide insurance for their uninsured populations. While the solutions found may not be perfect, they will certainly help some of the nations' medically uninsured and underserved. Thus, advocates should find out what state insurance programs exist, as well as be aware of the new COBRA provisions which will provide continued access to insurance for some LSC eligible clients.

IV. STATE & LOCAL GOVERNMENT MEDICAL ASSISTANCE PROGRAMS

Traditionally, state and local government medical assistance programs were financed through county property taxes.⁴³ However, many counties have raised their property tax assessments to limits prescribed by state statute and have little flexibility to obtain alternative revenue.⁴⁴ Thus, some states have begun innovative indigent health care programs by supplementing county dollars with funds from the state, hospitals, and private payers.

A. State and Local Programs

1. State/County Funded Programs

The new Texas Indigent Health Care and Treatment Act establishes the responsibility of county governments and public hospitals to provide certain mandatory services for medically indigent persons.⁴⁵ Counties must fund their indigent care obligations from property tax revenues; the Act prohibits a citizen vote to reduce the tax rate necessary to provide the required medical services. The state of Texas will assist in indigent care financing only after counties have expended 10% of their general revenue on indigent care. Eligibility for the care parallels Texas AFDC standards. A county hospital district or public hospital may request a "nominal" copayment toward the cost of care, but assistance cannot be reduced or denied if the copayment is not made. A separate bill, the Primary Health Services Act, authorizes the Texas Department of Health, at its discretion, to contract for or provide outpatient services to poor persons who reside in medically underserved areas of the state.⁴⁶ Funding for this state program is limited to an annual state appropriation.

Nevada has recently created an Indigent Health Care Investment

Trust Fund to assist counties in meeting their indigent care responsibilities.⁴⁷ The Fund will be financed through a three cents ad valorem tax on every \$100 of assessed property value in each county. Each county must have an indigent care fund. Ten percent of the county funds will be placed in a statewide supplemental assistance fund. If a county expends all of its fund on indigent care, it may apply for reimbursement for additional care from the statewide fund. Each county establishes its own eligibility criteria and procedures.

2. Selective Contracting

Some states are using a prudent buyer approach to purchase care for the medically indigent. Contracting providers are reimbursed on a flat fee basis. Arizona was one of the first states to utilize such a system.⁴⁸ Providers participate in a statewide competitive bidding process. Contracts are awarded to the lowest bidder who agrees to act as a case manager and provide or authorize health services for medically indigent persons. Nonparticipating providers generally receive payment for emergency care only. Unfortunately, eligibility standards for the program are low: approximately 40% of federal poverty income guidelines. State general revenues and county property taxes are used equally to fund the program.

In 1983, Colorado passed legislation authorizing selective contracting with twelve hospital providers of indigent health care services.⁴⁹ The program is funded 100% from state appropriations; however, each provider must expend a minimum of 3% of its adjusted operating expenses on uncompensated care before seeking reimbursement from the program. On a monthly basis, providers are paid their pro-rata share of the annual medically indigent appropriation. To date, the vast

majority of the funds have been allocated to two major hospitals in the Denver-Boulder area. Reimbursement levels approximate 50% of actual hospital costs. 59% of the fund must be allocated to preventive care; one percent, to patient transportation; the remainder, to inpatient hospitalization. The program operates on a sliding fee basis, with persons whose incomes are up to 230% of the poverty income guidelines eligible for reduced cost care.

Illinois contracts with various metropolitan area hospitals for the provision of care to the medically indigent who live in urban areas.⁵⁰ Contracting is based on a specific volume of patient days. When a facility runs out of days, medically indigent persons are referred to neighboring facilities with additional patient care days. The program is funded by state and county appropriations. Each hospital uses uniform income eligibility guidelines for indigent care (approximately 50% of the poverty income guidelines).

The prudent buyer approach is touted as a cost-effective way of delivering indigent care. However, the systems can have drawbacks. Medical indigents lose the freedom to choose their own providers. In addition, there have been reports of lack of access and numerous other abuses in the Arizona program.⁵¹ By design, such programs have the potential to raise significant barriers to health care access because the primary care physician, who must authorize all indigent medical care, has a financial incentive to provide as few services as possible. Without authorization, hospitals and clinics are likely to refuse treatment to the poor.

3. Financial Support for Hospitals

Arkansas recently created the Indigent Health Care Investment Trust Fund from a \$12.5 million federal Medicaid rebate received in 1984.⁵² The funds are to be invested so that the interest payments and/or principal can be transferred to the State Indigent Health Care Fund to finance the delivery of medical services to the indigent. Hospitals will be required to provide an established level of uncompensated care before being eligible to seek reimbursement from the Fund. For-profit hospitals will be given credit for the taxes they pay, and hospitals which receive county tax revenues will have such appropriations taken into consideration.

The Oklahoma Indigent Health Care Act funds indigent care through income tax check-off contributions by state taxpayers.⁵³ Counties reimburse hospitals from county funds, and the state makes an annual supplemental payment from the income tax fund to those hospitals with large numbers of indigent patients. The annual state payment is based on the ratio of each hospital's annual indigent care charges to the total amount of annual indigent care charges for all participating hospitals. Eligibility criteria parallel the poverty income guidelines, but other persons may obtain assistance if they have a catastrophic illness causing a debt which exceeds 50% of their annual gross income.

Nine states have, or are in the process of implementing, rate setting systems for payment of inpatient hospital services.⁵⁴ Over half of these programs include a provision for indigent care. In Maryland and New Jersey, for example, each hospital's rates are increased by an uncompensated care factor based on the amount of indigent care the facility provides. Low-income advocates in some of the

rate setting states have complained that the systems lack eligibility standards for low-income persons and offer little incentive for facilities to collect bad debts. In recent months, a number of these states have begun to adopt eligibility and bad debt collection policies.⁵⁵ On the whole, rate setting programs, such as those existing in New Jersey and Maryland, encourage a broader distribution of uncompensated care patients among hospitals.

5. Catastrophic Health Expense Programs

Idaho counties have sole responsibility to provide indigent care to county residents.⁵⁶ To insure against catastrophic health expenses, the Idaho Association of Counties has established a catastrophic health care fund.⁵⁷ Each county pays premiums into the fund raised from a sales tax based on a per-capita formula. All indigent hospitalization costs over \$10,000 in a given year will be reimbursed from the catastrophic fund. Counties are responsible for determining the residency, income, and resource status of indigents.

In 1984, South Dakota created a Catastrophic County Poor Relief Fund which will permit any county to draw from the fund when a medically indigent resident incurs hospital or medical expenses in excess of \$20,000.⁵⁸ Hospitals will be reimbursed for 90% of their indigent care costs in excess of \$20,000. The program was originally funded with a \$500,000 state appropriation and in the future will be funded by annual county tax assessments. The Nevada Indigent Health Care Investment Fund similarly will reimburse counties for indigent patient expenses in excess of \$25,000.⁵⁹

B. Enforcing State and Local Financing Programs

State and local government obligations to provide medical care

for indigents exist only where derived from state statutes and/or constitutions.⁶⁰ The extent of the obligation depends upon the express terms of the statutory or constitutional provision, legislative intent, and judicial interpretations of the provision.

The indigent care statutes in Idaho, Illinois, Nevada, South Dakota and Texas, for example, are mandatory in nature. Thus, they create a duty which cannot be avoided by neglecting to raise necessary financing or promulgate administrative regulations. Nor may program administrators establish impermissible restrictions on eligibility or scope of services. Where inaction or overbroad action of a governmental agency or official is shown to be illegal or arbitrary, a court, by writ of mandamus or mandatory injunction, will require the administering body to take affirmative action to perform its specified duties.⁶¹ In Madera Community Hospital v. Madera County,⁶² a California court granted a writ of mandate to a hospital seeking to compel funding of the county medical assistance program and required the promulgation of needed regulations for the program. Similarly, the West Virginia Supreme Court of Appeals permitted a mandamus action against state officials who allowed care provided by the state mental hospital to fall below statutory requirements.⁶³

In Florida, state and county governments are statutorily required to share costs for hospitalization provided to mental health patients.⁶⁴ When a county refused to contribute its share of cost, the Florida Supreme Court permitted a mandamus action and ordered the county to contribute the necessary matching funds.⁶⁵

The lack of available funds does not exempt governmental entities from their statutory obligations to provide medical care for indigents.

In City and County of San Francisco v. Superior Court,⁶⁶ a general assistance case, the court ruled that the county had a mandatory duty to relieve and support its indigents. The excuse that it could not afford to do so was unavailing. Similarly, a New York court recently ruled that a county may not evade its obligation to provide for the welfare needs of its residents because of county administrators' refusal to allocate necessary funding.⁶⁷ In an attempt to avoid such decisions, the Nevada indigent care statute explicitly limits the state obligation to annual appropriations which the legislature deems sufficient.⁶⁸

The Indigent Care statutes of Arizona, Arkansas, Colorado, and Oklahoma are not mandatory and merely authorize governmental entities to provide indigent medical care. Such laws may yet be interpreted to impose mandatory duties. In Industrial Commission v. Navajo County,⁶⁹ the Arizona Supreme court ruled that, since the counties had "exclusive" authority to provide care for the poor, individual county governments had mandatory duties to provide necessary hospital and medical care for their sick. Colorado⁷⁰ and Arkansas⁷¹ courts have likewise interpreted discretionary statutes to create mandatory duties to provide some quantum of medical care to the poor. In addition, several courts have ruled that Constitutional provisions authorizing poor relief must be given a broad construction consistent with their benevolent purpose.⁷²

Rate-setting (and revenue pooling) states which have not established hospital eligibility criteria or procedures for the provision of uncompensated care may be in violation of state and federal government due process requirements.⁷³ Written standards should be promulgated to prevent arbitrary or capricious program administration.

Where care has been rendered to a potentially eligible individual and not reimbursed by the state or county governments, hospitals often sue governmental agencies on a quasi-contractual theory. A court may imply a promise to pay absent an express contract, especially when the governmental entity has a mandatory duty to provide indigent medical care.⁷⁴ Moreover, medical indigents are third-party beneficiaries of any express contract between hospitals and state or county governments.⁷⁵

Legal Services advocates are routinely requested to defend collection actions hospitals bring against uninsured persons. Advocates should implead the governmental agency as a defendant on the basis that the obligation to reimburse the hospital rested with the government rather than an impoverished client. Advocates should allege agency statutory obligations to provide indigent care and assert that the client's care fell within the required scope of services.

V. Conclusion

The majority of states are investigating ways to pay for the medically indigent. Undoubtedly, a number of states will adopt variations of the funding mechanisms discussed herein. As legal services attorneys, we should become familiar with these programs early on so that the improved access that they promise can be realized.

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FOOTNOTES

1. Iglehart, 313 N.Eng.J.Med. 59 (July 4, 1985).
2. National Conference of State Legislatures, 1985 Health Care Cost Containment Legislation (Jan. 1986) [hereinafter cited as 1985 Health Care Cost Containment Legislation].
3. N.Y.Pub.Health Law §2807-d(1986).
4. New York allowed its all payer waiver to expire in 1985. Now, hospitals' Medicare reimbursements are calculated according to the national DRG prospective payment system. Some of the funds from the statewide pool are dedicated to assist hospitals having difficulty making the transition from the state all-payer system to the Medicare system.
5. No. 85-2538 (Sup.Ct. April 17, 1986).
6. Id., slip op. at 13. See also 42 U.S.C. §1395x(v)(1)(A); 42 CFR §405.420(d).
7. Id. at 16. See 42 U.S.C. §1395ww(d)(5)(C)(i).
8. Mass.Gen.Laws.Ann. ch 6A, §§51 and 75 (1985).
9. 29 U.S.C. §§1001-1381.
10. 29 U.S.C. §1144.
11. Dedeaux v. Pilot Life Insurance, 54 U.S.L.W. 2182 (Oct. 10, 1985). See also Metropolitan Life Insurance Co. v. Mass., 53 U.S.L.W. 4616 (June 4, 1985). For a more detailed discussion of ERISA's preemption provisions, see Ensminger and Law, "Doctors, Patients and Insurance," N.Y.U.L.Rev. (forthcoming 1986).
12. Fla.Stat. §154.35 (1984).
13. W.Va.Code §16-29C-1 et seq. (1985).

14. Conversation between William Cronch, W.Va. Healthcare Cost Review Authority, and Perkins, National Health Law Program (March 14, 1986).
15. S.C.Code §§44-6-5, 44-6-140, 44-6-20 (1986).
16. See N.Y.Pub.Health Law §2803(2)(a)(iii) (1986). Conversation between Wessler, Community Legal Services, New York, and Perkins, National Health Law Program, Los Angeles (March 4, 1986).
17. Id.
18. 114.1 CMR 30.00 et seq. (eff. July 1, 1986).
19. See Administrative Law §§381-427 (West's Digests).
20. 42 C.F.R. §§124.601 et seq. (1979).
21. 42 C.F.R. §124.603(c)(1) (1979).
22. Conversation between Kamer, Pine Tree Legal Assistance, and Waxman, National Health Law Program (March 14, 1986).
23. Conversation between Andrews, S.C. Legal Services Ass'n., and Waxman, National Health Law Program (March 14, 1986).
24. Office for Civil Rights, U.S. Dept. of Health and Human Services, A Guide to Planning the Hill-Burton Community Service Compliance Review, at Tab A (July 1, 1981). For additional outreach litigation strategies, see note 73 and accompanying text, infra.
25. Nineteen states mandate continuation policies and 31 states require insurers to offer conversion policies. Inter-Governmental Health Policy Project, State Programs of Assistance for the Medically Indigent Appendix A (Nov. 1985) [hereinafter cited as State Programs of Assistance for the Medically Indigent]; 1985 Health Care Cost Containment Legislation, supra note 2 at 20.

26. Continuation policies must be provided for 18 months following job termination (or reduction of hours) and for 36 months in case of death of covered employee, divorce or legal separation from the covered employee or loss of coverage due to Medicare eligibility or age of a previously dependent child. §10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 (April 7, 1986) [hereafter cited as COBRA].
27. States determined that a state subsidized program for the unemployed would be quite costly. A Maryland study, for example, determined that it would cost the state between \$1.4 million to \$11.6 million for six months of a voluntary program and between \$16 million and \$23 million for a mandatory program. Department of Legislative Reference, Report of the Special Joint Committee on Health Care for the Uninsured 6-7 (Dec. 1983).
28. Share Care began in 1983 with one time federal jobs bills money as well as federal block grant funds and donations of free care. See Memorandum of Morrison, Administrator, Wisconsin Division of Health, "Health Care for Wisconsin's Uninsured," 7-8 (Nov. 1, 1985).
29. Id. at 8.
30. State Programs of Assistance for the Medically Indigent, supra note 25 at 123-25.
31. See, e.g., Erwin v. United Beneficial Life Ins. Co., 70 N.M. 138, 371 P.2d 791 (N.M. 1962); White v. Blue Cross of Virginia, 215 Va. 601, 212 S.E.2d 64 (Va. 1975).
32. States with risk pools are CN, FL, IN, MN, MD, VT, NB, ND, RI, and WI. 1985 Health Care Cost Containment Legislation, supra

note 1 at 19. Other states considering risk pool legislation are Kansas, New Jersey, and Tennessee. National Conference of State Legislatures, Major Health Issues for States: 1986 at 30-32 (Feb. 1986).

33. See generally, State Programs of Assistance for the Medically Indigent, supra note 24.
34. Costs for both Rhode Island and Alaska have increased dramatically. For example, Alaska's CHIP appropriation went from \$300,000 in 1977 to \$2,300,000 in 1985. During the 10-year operation of Maine's CHIP (from 1974-1984), both program costs and the number of recipients sky-rocketed. Minnesota terminated its program because of high costs. State Programs of Assistance for the Medically Indigent, supra note 24 at 75, 152, 178, 239.
35. See generally, Danzon and Conover, Health Care for the Uninsured Poor of North Carolina (1985) (available from Center for Health Policy Research and Education, Duke University); Danzon and Conover, "Health Care for the Uninsured Poor: Evaluating the Options," Presentation at the November 1985 meeting of the American Public Health Association (available from National Health Law Program, Los Angeles, Cal.).
36. Administratively, state systems could operate in a number of different ways. Beneficiaries could be given a voucher, based on the previous year's income, to choose from among state approved plans. Or, individuals could be given a refundable tax credit to purchase a health insurance policy. The state could allow all insurance companies and HMOs to market their programs or award contracts to a few on a competitive bid basis. States could

permit approved plans to pay on a fee-for-service basis or restrict approved plans to a capitated payment system.

37. 1985 Wis. Laws, Act 29.
38. Guidelines for the development of SHIP are: provide an opportunity to enroll all Medicaid recipients into the program; avoid adverse selection; offer a choice of catastrophic or comprehensive coverage; utilize a prepaid, capitated payment system; use insurance vouchers and direct payments to health care providers; require enrollee contribution on an income-based progressive scale; require competitive bids among prospective providers and administrators; avoid creating incentives for employers to cease offering coverage to their employees; and obtain maximum federal funding for the program.
39. Danzon and Conover, Health Care for the Uninsured Poor of North Carolina, at 170 (1985).
40. Reimer, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions 22-23 (Dec. 24, 1984).
41. P.L. 97-473, 96 Stat. 2605 (1982) amending 29 U.S.C. 1144(6)(A) and 1144(5)(A)-(C).
42. COBRA, supra note 26.
43. Stern, Medical Services by Government, at 10 (1963 Supplement). See generally, Lewin & Lewin, "A Threat to Teaching Hospitals' Traditional Mission - Price Competition is Changing the Ground Rules about Caring for the Poor," 2 Business And Health 28 (October 1985).
44. See, Gold, "Results of Local Spending and Revenue Limitations: A Survey" in Perspectives on Local Public Finance and Public Policy (1982).

45. Tex. S.B. 1 (1985).
46. Tex. H.B. 1844 (1985).
47. Nev. Rev. Stat. §§428.000 et seq. (1982).
48. Ariz. Rev. Stat. Ann. §§36-2901 et seq. (1982).
49. Colo. Rev. Stat. §26-15-101 et seq. (1983).
50. Ill. Ann. Stat., ch. 23, §§21 et seq. (1984).
51. Kirkman-Liff, "Refusal of Care: Evidence from Arizona," 4 Health Affairs 15 (Winter 1985).
52. Act 411 of the Arkansas Laws of 1985. So far, \$1.5 million of the Investment Fund has been allocated to the Department of Human Resources to expand Medicaid coverage to pregnant women, and \$0.5 million has gone to University Hospital for the expansion of its high-risk maternity facility. See generally note 15 and accompanying text, supra, for a discussion of South Carolina's county/hospital financed revenue pool.
53. H.B. 1802, Oklahoma Legislature (1984).
54. Intergovernmental Health Policy Project, State Programs of Assistance for the Medically Indigent (November 1985). See also, Perkins, "Health Care Cost Containment and the Poor," 19 Clearinghouse Review, 831, 835-37 (December 1985). The New Jersey, Maryland, New York, and Massachusetts programs include uncompensated care payments. Connecticut, Maine, Washington, West Virginia, and Wisconsin are in the process of implementing rate setting systems; only Maine's program includes specific indigent care provisions. Wisconsin will partially reimburse bad debt. Id.
55. See, e.g., 8 N.J.R. 31B-4.38; note 18, supra, and accompanying text.

56. Idaho Code, chapter 34 §§31-3501 et seq.
57. Intergovernmental Health Policy Project, State Programs of Assistance for the Medically Indigent at 127 (November 1985).
58. S. 125, South Dakota Legislature (1984).
59. Nev. Rev. Stat. §§428.00 et seq. (1985).
60. See, e.g., Harris v. McRae, 448 U.S. 297 (1980) (no constitutional right to health care).
61. 54 C.J.S. Mandamus §151.
62. 155 Cal. App. 3d 139 (1984).
63. E.H. v. Matin, 284 S.E. 2d 232 (W. Va. 1981).
64. Fla. Stat. Ann. §§394.451 et seq., 394.76(a) (West).
65. Sandegren v. State of Florida ex rel. Sarasota County Public Hospital, 397 So. 2d 657 (Fla. 1981).
66. 57 Cal. App. 3d 44 (1976).
67. Wilkins v. Perales, 487 N.Y.S. 2d 961 (N.Y. Sup. 1985).
68. Nev. Rev. Stat. §§428.00 et seq. (1985).
69. 167 P.2d 113 (Az. 1946).
70. McNichols v. City & County of Denver, 74 P.2d 99, 104 (Co. 1937).
71. Board of Trustees, Univ. of Arkansas v. Pulaski County, 315 S.W. 2d 879 (Ark. 1958).
72. DeJarnette v. Hospital Authority of Albany, 23 S.E. 2d 716 (Ga. 1942); Graham v. Reserve Life Insurance Company, 161 S.E. 2d 485 (N.C. 1968); and Board of Managers v. City of Wilmington, 74 S.E. 2d 749 (Del. 1953).
73. See, Madera Community Hospital v. County of Madera, 155 Cal. App. 3d 136 (5th Dist. 1984); Baker-Chaput v. Cammett, 406 F.Supp. 1134 (D. N.H. 1976); and White v. Roughton, 530 F.2d 750 (N.D. Ill. 1976).

, 74. See, St. Thomas Hospital v. Schmidt, 406 N.E. 2d 819 (Ohio 1980).

75. Restatement (Second) of Contracts §302: "Unless otherwise agreed between promisor and promisee, a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties and...the circumstances indicate that the promisee intends to give the beneficiary the benefit of the promised performance."

THE EMPLOYERS' PERSPECTIVE: Clark Kerr, Bank of America

(Transcription of oral presentation)

I think we all ought to immediately start kicking as hard as we can if we're going to solve this crisis.

Business is kind of the "Johnny come lately" to the uncompensated health care crisis, and that has both an advantage and a disadvantage. The disadvantage is that we honestly admit we're kind of naive in this area -- we're still learning. The positive is that we bring, I think, a fresh perspective, and I'm going to mention several things that I haven't heard anybody here mention yet, and that's always the advantage of coming into something new.

Of course, in the past, we were the unknowing partners of health care providers in helping to provide care for the uninsured and the uncompensated care cases, because we permitted the hidden cost shift. It was something we weren't aware of, to be honest with you. It worked pretty well and maybe we can say ignorance is bliss.

We've all come under some very stiff competition. We've done everything we can to restrict costs in all areas, including health care costs. This has allowed us to do such things as contracting the PPO's and so on, which has limited, of course, as you've heard, the ability of this hidden cost shift.

We do recognize that we have a responsibility in this area. I participated with the Washington Business Group on Health in a task force on the national level looking at this issue. The California Chamber also has a subcommittee that has looked at this issue. But today I want to talk about a unique coalition in the San Francisco area that is trying to find some solutions.

This group in San Francisco realized early on that there were two requirements to try to come up with solutions. First, is that you need all parties who have an interest and a concern in this issue to work together to try and find a solution and to work in good faith. It's not just the hospitals or just the doctors or just the employers.

Secondly, we realized that we had to look at the total issue, and it was a much broader issue than just the question of financing.

The group that I'm talking about is called the Bay Area Health Task Force, and is comprised of a rather interesting group of people. It has some big employers -- it has Bank of America, it has Safeway, Pacific Bell, Chevron, PG&E -- household names, big companies. It also has labor representatives. Bill Henderson and the labor coalition are involved and labor's voice is heard. The San Francisco Medical Society is involved; the president and the executive director. The West Bay Hospital Association and three or four of the San Francisco hospitals are participants. We have the Public Health Department and we have

Kaiser, and it's all being hosted by perhaps an ideal combination -- the United Way -- a rather neutral force between purchasers and providers. We have staff work provided by the local HSA and by Stanford Research Institute. The whole effort is being funded by grants from the corporate world and from private foundations.

We see as our mission, a simple mission which has turned out to be fairly complex, simply to ensure that all in need receive quality health care and that it is efficiently managed and expressly paid for. Early on we realized that we were dealing with three broad areas. We realized that one of the things that had to be done was to minimize the occurrence of uncompensated care. There were several ways to do this. One was to get more people covered by health insurance, which has been mentioned. Another way was to look at trying to prevent those diseases that could be prevented among everybody, including those who were uncompensated or uninsured. If you have people covered by insurance and try to prevent disease among those that work, that would be a good step a minimizing the incidence of costly disease.

Secondly, obviously when care was needed, we wanted to ensure that this was carefully and efficiently managed, because we have seen in the corporate world that not all the time is health care sufficiently managed and that certain things had to be done here.

And finally, of course, it had to be paid for. It had to be expressly paid for, because in the competitive mode, it no longer

was possible to rely on the cost shift and also be competitive at the same time. You could not go to Bank of America or Chevron, have us look at your costs and decide that you were a hospital that we wanted to contract with because your rates would be higher as you passed on those costs. So in order to compete, costs had to be expressly paid for.

As we looked deeper we found several things. The Washington Business Group on Health found in the study they did that over half of all the people without health insurance in this country are employed people, usually with small businesses, sometimes self-employed. We also found some surveys reported in Business Insurance that about 37% of all companies with 100 or less people offer no health insurance at all to their employees.

So one of the immediate needs was to try and find ways to have more employers offering health insurance to their employees. The main issue here was a question of workability. And two things looked like they needed to be done. One was to create risk pools, because often a single individual, or a very small group of individuals can be very risky for an insurer to take care of. So there's a need to pool these risks.

The second area became clear too, and that was that it was important that there not be government mandates for health services on health plans because that makes them a lot more expensive. The end result of having additional mandates, and there've been a lot of attempts here in California, be it

podiatrists in the past or acupuncturists or mental health or drug and alcohol and so on, is to raise the costs of all the health care plans. What this does is mean that companies will not offer anything, not even acute care which is extremely needed.

This week there was a discussion on the Bronzan mental health bill. If that had been mandated (it was not) there are estimates that that alone would have cost \$100, \$150, \$200 additional per employee per year to the cost of health care. So those were important things to try to be avoided.

We also realized that if we got more companies to offer health insurance, we also needed to have the extension of that insurance when people were divorced or laid off and so on. That, of course, has been taken care of through COBRA, and that's fine, provided you're working for the company with 20 or more people and provided, of course, that company had health insurance in the first place.

Another area that I think we were brand new in discovering was that there was a concern among bigger companies in the area of flexible benefits. More and more big companies are getting into flexible benefits for two reasons: they're very popular with employees and they also tend to cost appropriations less money. Many times you can spend less and get more bang for your buck if you want to do it.

But there were two models that were being looked at around the country. One, which is okay, has a core program that everybody has and then you can trade some of the extras. Another model allows people essentially to trade away anything for anything else. In other words, if you want to trade away all of your health care and buy an extra week of vacation, you can. And we saw that as a potential concern in that if you were one of the 18 to 25 year olds -- you remember those days -- that's when we are all immortal -- what would you do? Would you take the health insurance or would you get an extra week of vacation? Not too much of a question. So that became an issue we were concerned about.

There was also another issue. You can lead a horse to water but how do you make him drink? We have at the Bank of America, and all companies, a certain percent of employees who even though they've got health insurance available, often paid for -- three quarters -- and so on, or more -- if when available, don't opt for it anyway. So how can you convince people to take it, and how can you convince those that are employed but have other resources to buy insurance on their own? So there was that whole question, and since COBRA came in, some of us were thinking maybe in the advertising to try and convince individuals to do this, we ought to get Sylvester Stallone, on TV or something, to plug for uncompensated care and say that, you know, it's the "in thing" to have health insurance and maybe give them a little threat if they don't.

But I think seriously there's an issue that has to be looked at, and that is there are people in society who could afford health insurance that aren't getting any. I think one of the messages we have to get out is that this is not a society of free lunches, that all of us pay taxes, all of us work, and all of us have to pay our share and if you can afford insurance, you have to get it.

Then we started thinking about ideas such as the assets spend-down. If you had, you know, a BMW and you had a nice house but you didn't bother to get insurance, maybe you should get that uncompensated care at the counter or anywhere else, but be required to spend-down. The idea has also surfaced on a loan concept. If you really had the money and you could have bought insurance but you decided that you'd rather have that extra week of vacation or extra trip to Europe, that just like a student loan, if you had to get health care and you had \$2,000 in bills and you had no health insurance, you're going to have to pay that back over a period of time. Again, ways to let people know that they have individual responsibilities.

Also, we discussed the area of what about those people who would like to have health insurance -- maybe so-called uninsurable, people with health care conditions -- but can't get it. And there are at least a couple of ways of looking at that. One has been discussed -- the uninsurable pool, AB 600, which is now being looked at. I think that that's certainly something

worthy of looking at. There is a problem that you can go up, I think in this case, to about 150% of the actual cost of premium, which gets to be very expensive. What it means is that only the relatively well-to-do will be able to afford this type of payment. To have a tax on everybody to do this probably would be the fairest way to do it. As written, you may have lower paid clerks paying three-tenths of one percent of the taxable income towards something that might benefit only the better off people. I'm not sure that's fair.

Another idea that was surfaced by the California Chamber of Commerce was why not let these people buy into MediCal. Don't start a new program. Just have them have the ability to buy into MediCal. In that case, they'd have the benefit of both contract savings and discounts that have been arranged by MediCal instead of starting a new program.

Of course, there's also the area potentially of expanding MediCal eligibility, and another idea that was surfaced by the Chamber was the idea that maybe you could let people buy in on a graduated agreement cost. In other words, if they could afford a quarter of the cost, they would pay that much. This would be a fair way to get people into MediCal and increase the number who are getting coverage.

So those all seem to be possibilities. If we can get more health care insurance available, try to convince people that they ought to get that health insurance when it is available, try to

get the people who like to pay for their health care conditions some sort of access, and finally perhaps expand MediCal eligibility.

Now, there is that other area -- the area of prevention. Some people still aren't going to be able to get health care insurance. Prevention really can work. We've seen it in the corporate setting and we know it does work. What needs to be done is to look at those areas that you can spend money that will save people's lives and improve the quality of lives and also has the potential for a return on investment by staving off some diseases that didn't have to happen. Such things as better efforts for prenatal care, more effort getting immunizations for kids. We've had very much success in hypertension with adults, Glaucoma screening is also a possibility.

However, you're still going to have cases of uncompensated care. So then we became concerned that when you do have these, you need to make sure that whatever system is set up, that care is well managed. We, in the corporate world, found that we were not managing the care well and that things had to be done, whatever system is thought of. There are really about four ways to manage care.

One way is the current way and that's the underfunding of care. 'Don't pay enough to cover' policy. That gets pretty efficient care in that nobody's going to do anything extra if they don't have to because they're not getting paid.

Another potential is capitation because the incentives are known to be as effective. Fee for service can also be effective provided you've done one of two things: one is to do like the corporate world and have extra open pools. Make sure that you've got a utilization review in place that you have a case management system under certain circumstances, that you have alternatives developed, such as home care and hospice, which are less expensive and can do the job as well or better -- those types of things. The other one which is recommended by the insurance agency is if you're going to get into this situation, choose only those health care providers that are already proven to do an excellent and efficient job. Those all seem to be options.

You've got to pay for this somehow and obviously the two general ways are some sort of pool from a bed tax or the more general state tax or federal tax of some sort.

So, with this general background, what did we decide needed to be done? Where are we at this point. One can see that this is pretty tentative, but this is where we are at this point. We decided there's really a short term strategy and a longer term strategy. The short term strategy realizes that at this point the real burden in California is on the county hospitals. At least in San Francisco the hospitals have been telling us that recently they've had a fairly effective front door policy. Essentially, if you walk in that front door, they ask you for proof of insurance or cash on the block. If you don't have

either one, turn around and you walk out the door and go to the county hospital. And that apparently has been very effective in getting down the percent of uncompensated care in the private hospitals. So we realized that we needed to give, at least in the short term, some help to the county hospitals.

The action plan that we've come up with is, first of all, in terms of how we minimize that need or the occurrence of uncompensated care. We're going to be pursuing either multiple employer trusts or some similar vehicle to try and get pooling among small employers and self-employed people. Once you define this, you have two issues: one is how you market this to these companies or to these self-employed people, which is a marketing challenge. The second problem is how do you give insurers an incentive to want to offer these products? Because of past experience in these areas, you have two problems. Those who opt for this are usually the worst risk. You get adverse selection. It can be very expensive and difficult for insurance companies. The other problem would be experience with rapid turnover. It seems like every year they change policies and you never can come out even. So those are two issues that needed to be decided.

Another area we're going to attack is how can you have a marketing program devised that you can aim at individuals who don't have insurance but do have access to insurance, (and) convince them to get it. We applied, as a group, for a Robert Woods Johnson grant to try to address both of those two issues, the individuals and marketing.

Another area -- we're going to come out with information on the flexible benefits concern. I've found in my talks around the country that nobody else seemed to be aware of this problem. I've talked to benefit managers who are considering the area of trading and they never considered this possibility in this issue. So it's really an education issue, one that we're going to take up a role as educators so they won't make this mistake.

We're also going to take a position fairly soon on either supporting the uninsurable pool or to buy into MediCal for those who have health care conditions, and depending on some of the amendments that are going on now, there will be hard decisions.

We're going to look at the area of preventive health care approaches in a productive way. We're going to try to determine which -- I mentioned three or four things -- which of those really do work. Then we're going to look at the San Francisco area and find which of those services are now being offered and which are not. And for those that are not, we're going to try and seek funding perhaps through corporate foundations, try and get those services covered so that we can get those services out of people.

Then, in an effort to try and help the County Public Health Department, which includes San Francisco General, the county hospital, and health clinics, we're going to do several things. They have come up with a list of things that they need and we're going to see if the companies and others in the area can provide

some of these at no or low cost to the county hospital. They need more space. Right now the concern is that they have a lot of people in acute beds that aren't really acute care cases, but there's no intermediary setting for them. And so one of their needs is extra space to put these people that's not an acute care setting but where they can get some care. And, so we're going to try and see if we can find space. We're looking internally right now to see if we've got an empty branch that perhaps we can donate in the short term or whatever else might be available.

There's also a need for some computer capability and we're talking to certain companies who have computers. It may not be the ultimate state of the art but they're still pretty good. They need used furniture -- we all have some of that. They've even talked about the possibility, and I'm not sure how far we'll go on this one, to try, at least on a temporary basis, to arrange discounts. Discounts for things like phone services, since we've got a phone company; banking, since we've got banking; electricity, since we've got PG&S; and so on, to see whether or not these businesses can, at least in the short term, help out in this situation.

Another area that they're concerned about is the issue of bad debts, because they do have a lot of true charity cases but they also have people coming in that could pay, but simply say, 'hey, society owes it to me.' And quite honestly, none of us want to have those people getting a free lunch. They have asked whether

we could set up a private/public task force that would help them set guidelines for when and how hard you pursue bad debt. What are the guidelines -- so that you know how hard and when you can pursue this type of issue, which I think would help them and it would be important -- it's going to be important for us to support all this because we want to make sure we're supporting charity type of cases and not just the free lunch.

And also we're talking in terms of business and banking and also some of the other hospitals sharing some of our techniques for bad debt collection with the county so they can do a better job in pursuing these individuals.

So those are some of the short-term items that we have. In the longer term, we have asked ourselves a question: Is the system that asks that the county hospital be ultimately responsible for the uncompensated people and everybody else goes to the private hospitals really the best thing for society? And the way we're coming down is no, it really isn't, in our opinion, the best way. Because you're really aggravating a two tiered system. If you haven't got it, you go to the county; if you have got it, you go somewhere else. And that's not, I don't think, healthy for society. It's not good, based on past history, and we don't think it's healthy for the future.

What we would like to push for is a more open system where there would be the ability to have financing so that all hospitals, just as with MediCal and Medicare and everything else,

could bid if they wanted to for this business, and that there would be hospitals then that were -- other than county -- that could be reimbursed for this type of situation. So people could make a choice as to where they wanted to go.

This, of course, requires a couple of things. It requires that there be financing so that there can be some sort of price situation, if hospitals even want to bother bidding on, because right now there's not that much worth bidding on. So you've got to get some money, and where do you get the money? So then we came to the issue of the hospital pool tax type of concept versus the more general tax. Generally, the hospitals have said, and many people have said, that it's more of a societal problem than it is a health care industry problem. And in talking to employers -- about a month ago we had our meeting of the California Employer coalitions -- it was unanimously felt that, yes, it is a society problem, it's not a public or industry problem. Therefore, really in the longer term what makes sense is the more general tax, more general federal or state tax, unlikely as that seems now, rather than a hospital pool or a health care provider tax. And of course, people said, 'well, that's impossible.' I said, 'sure, it's difficult, but if you get business and labor and everybody else behind it there's nothing that's impossible.- So in the longer term you may very well see us pushing for that type of funding as opposed to a health provider tax.

Secondly, of course, if you do get the money and this type of situation is implemented, it has to be managed effectively. And we have not any ideas yet at this point whether we prefer a capitated system or a fee for service system that has the goals we've discussed. But I think whatever system, you must have controls.

One of the controls that is needed for uncompensated care -- actually for everybody -- is also evaluation of good quality of outcome -- quality of care that's being given. We don't have enough of that now for anybody, and you're going to see employers over the next year, two years, surfacing that issue. In fact, my prediction was in the next two or three years you're going to see employers putting a lot more emphasis on that than on cost, because that's the next big issue coming up. I will let you know that, generally as we get into this, we are not content with the quality of care that we're seeing in the industry at this point, in some segments or parts of the industry, so you're going to see a big push in that area.

So in conclusion, I think we've got a tough problem, we've got a growing problem. But provided all the parties that are interested and involved in it are willing to make a good faith effort working together, I think we're going to solve the problem. I think the end result is we're going to have better access to care, it's going to be better care, and we're going to ensure that we get more value for our dollar.

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PROVIDING INDIGENT HEALTH CARE IN A RURAL COUNTY

The Fresno County Experience

Introduction

For many decades, the primary providers of indigent health care in California have been the counties. Virtually every county established its own county-operated hospital, where medical services were offered to those who could not afford private care. The nature and quality of these services varied from county to county, depending on the level of resources committed by each county for such care.

During the 1960's and 1970's, federal and state programs were established which assumed a growing responsibility for providing, and funding, a consistent level of indigent health care services throughout the state and nation. The federal Medicaid Program, through its California version known as Medi-Cal, has funded a comprehensive range of health care services to indigent Californians for over a decade.

These services, however, were not only comprehensive--they were also expensive. As costs escalated during the late 1970's and early 1980's, officials at both the federal and state levels began to seek fiscal relief from the growing burden of indigent health care.

The federal government has periodically reduced their costs by tightening eligibility criteria, usually at the expense of state and local budgets. Similarly, the State of California has explored ways to reduce health care costs. The most significant action taken to date has been the return to the counties of the responsibility for providing health care services to adult indigents in January, 1983.

As a result, counties in California are once again in the position of providing unavoidable, necessary health care services to many indigent persons, without the level of compensation for these services that had earlier been provided by the federal and state governments. The inescapable conclusion is that the counties, as the providers of last resort, are being required to offer the very same costly medical services that federal and state governments feel they can no longer afford.

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To compound the problem, at the same time that the responsibility for these services is passing to the counties from federal and state levels, the counties themselves are confronting a fiscal crisis. On one hand, just as Congress curtails its funding of medical care, it is also eliminating General Revenue Sharing, originally established to compensate states and counties for discontinued federal services, such as these. Likewise, when the state chose to transfer to the counties full responsibility for adult indigent health care, only 70% of the resources needed during the previous year for the same population was allocated to the counties to fund those services.

Fresno County, like other counties in California, recognizes that the responsibility for these services cannot be passed any further. Counties are the providers of last resort, and they must either find a way to provide services, or make the hard decision that such services can not be provided.

An Overview of Fresno County

Fresno County represents a microcosm of the state as a whole. It is both rural and urban, both agricultural and industrial. It contains more than one hundred identifiable ethnic groups among its more than 600,000 inhabitants. Fresno County is the leading agricultural county in the nation. The value of its crops exceeds \$2 billion annually, far exceeding all other counties in the country.

Like other rural counties in the state, Fresno County is home to a large number of economically disadvantaged persons and families. The various programs administered by the Fresno County Department of Social Services assist more than 130,000 persons per month in the county. More than 25% of the county's inhabitants meet the federal poverty level definitions. The county's unemployment rate is one of the highest in the state, and the county has the fourth largest caseload in the state in the Unemployed Parent Program (AFDC-U), despite the fact that it ranks no higher than twelfth in general population.

In addition, there are large numbers of undocumented persons in the county. These persons are usually employed in the farm labor market, with its seasonal, unpredictable fluctuations. Because of this, most are also desperately poor. Furthermore, even though undocumented persons are generally not eligible for federal or state assistance, Fresno County is under court order to provide medical services to indigent undocumented persons who have no other financial resources for health care.

All of these factors contribute to the unusually high number of indigent persons in the county, many of whom require health care services on a regular basis. Fortunately, the county has maintained an excellent county hospital facility which, in many respects, has become a regional facility since many of the surrounding counties no longer have county-operated hospitals. Likewise, the Fresno County Health Department operates a number of decentralized health clinics throughout the county, which offer high quality health care services at strategic locations throughout the county. In addition, the Health Department provides comprehensive mental health services to indigents under the County Medical Services Program.

History of the Fresno County Medical Services Program

When the MIA (Medically Indigent Adult) transfer occurred on January 1, 1983, the immediate concern of Fresno County officials was to guarantee that the highest possible level of services was delivered with the funds provided by the state. The legislation governing the transfer required that there be no reductions in services to the extent that state funds were available. The task of the county was to use the state allocation as efficiently as possible, in light of the fact that it amounted to only 70% of the amount spent the previous year.

In an effort to accomplish this, the Fresno County Board of Supervisors adopted the following major policies:

1. Services for eligible indigents will be provided at county facilities only.

It was immediately apparent that the county could not merely continue the same service delivery system that existed under Medi-Cal, and contain costs within the 70% allocation. The only hope for the county was to centralize the delivery of health care services within county facilities, and anticipate that the resulting economies of scale would reduce the costs. There were special provisions adopted, of course, to allow for county facilities to contract with other providers if an eligible recipient needed services that were not available in a county facility (e.g., open-heart surgery).

This same policy was also applied to emergency services. Since state law requires any emergency facility in the state to provide emergency services when indicated, county funding of such services was limited to those provided at county facilities.

Consequently, any health care service provided to a Fresno County indigent by any other provider, either inside or outside the county, is not funded by the County Medical Services Program unless it was authorized by a Fresno County-administered facility prior to the delivery of the service.

2. Services will be provided at no cost only to those indigents whose income and property resources meet standards established by the Board of Supervisors.

Since there were existing income and property standards for Medically Indigent Adults under the previous Medi-Cal regulations, Fresno County established similar standards for the County Medical Services Program. The standards were set to correspond with the Medi-Cal standards which were in effect at the time. Since that time, the standards have been periodically updated, and still correspond with current Medi-Cal standards.

3. Services will be provided to Fresno County residents only.

By its very title, the County Medical Services Program is a county program. Consequently, it was determined early in the planning process for the program that only Fresno County residents would be eligible for services under that program.

The next step was to define the term "resident." The most pertinent section of the law in this regard is Section 17105 of the Welfare and Institutions Code, which applies specifically to the other major county assistance program, the General Relief Program. This section defines a county resident as a person who has resided continuously in the county for one year immediately preceding the date of application for assistance. As a result, the Board of Supervisors adopted the definition of residence found in Section 17105 for the County Medical Services Program.

Subsequently, the County made the decision to change the definition of residence to conform with the Medi-Cal definition, which states that residence is established whenever a client currently resides in a county and indicates an intention to remain.

An Overview of the County Medical Services Program

In the month of December, 1982, there were approximately 7,500 Medically Indigent Adults eligible for health care services under the Medi-Cal Program. However, this figure represented the total number of individuals who had been found eligible at any time in the prior twelve months, since Medi-Cal eligibility is generally reviewed and reestablished on an annual basis.

Consequently, when the County Medical Services Program was implemented the following month (January, 1983), with monthly recertification required, only 717 persons were approved as eligible for the program. Another reason for this low figure was the fact that approval or denial of eligibility was accomplished immediately, and clients therefore discovered, to their delight, that they needed to apply only at the time that they actually needed medical services.

Over the course of time, the number of eligible persons has progressively increased. For example, 3,532 persons were found eligible for services during the most recently tabulated month of April, 1986. This increase has been due, in some measure, to the periodic upward revisions that have been made to the income and property standards used in the program, and to the more inclusive definition of residence currently being used.

Of more concern to the county has been the escalation in the costs of services, and the simultaneous significant increase in the county share of these costs. The following table illustrates the costs incurred at Valley Medical Center, which is the major health care provider in the program, and indicates the shortfall in funding due to the inadequacy of the state allocation for these services.

VALLEY MEDICAL CENTER				
<u>Summary of CMSP Costs vs. State Payments</u>				
From 1/1/83 to 6/30/86				
<u>Fiscal Year</u>	<u>Cost</u>	<u>State Payments</u>	<u>Shortfall</u>	<u>Comments</u>
1982/83	Inpt. \$3,779,245 Outpt. <u>1,543,635</u>			program existed 6 months only in first year
	TOTAL \$5,322,880	\$5,024,303	\$ 298,577	
1983/84	Inpt. \$8,070,061 Outpt. <u>3,458,598</u>			Actual full year costs
	TOTAL \$11,528,659	\$9,273,508	\$2,255,151	
1984/85	Inpt. \$9,413,852 Outpt. <u>3,685,090</u>			Actual full year costs
	TOTAL \$13,098,942	\$9,103,513	\$3,995,429	
1985/86	Inpt. \$10,461,904 Outpt. <u>4,385,212</u>			Estimate, based on 11 months actual costs
	TOTAL \$14,847,116	\$10,944,498	\$3,902,618	

The Major County Concern

It should come as no surprise that the over-riding concern of Fresno County, and undoubtedly many other counties in the state, is the financial security of county programs to provide health care services to indigents not eligible for the Medi-Cal Program. From the beginning of the program, the state allocation for these services has been inadequate to fund the services needed. This has required consistently growing county expenditures for vital and necessary health care services for the most vulnerable members of our community.

These growing county costs for indigent health care have occurred at a time when counties are faced with other unavoidable and increasing demands for county expenditures. The counties, like the federal and state governments, are embroiled in a severe fiscal crisis. Unfortunately, the options available to the counties are severely limited by both state and federal law.

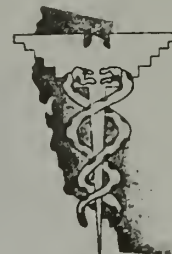
Consequently, the counties must look to state and federal officials for relief in this regard. With no additional discretionary funds available in the counties, the most likely options seem to be that either additional revenues must be provided for counties to use for this purpose, or health care delivery systems for indigents must be reviewed, with state and federal governments joining the counties in making the difficult decisions regarding these services.

We recognize the difficulty, at all levels of government, of locating new revenues at this time. However, we worry about a society which, when faced with the need to reduce expenditures, allows the health care needs of its indigent population to be sacrificed in that process. The counties have demonstrated their commitment in this regard by assuming a difficult share of cost for these services during recent years. We ask that other levels of government similarly indicate their commitment by sharing in those increased costs.

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The California Health Federation, Inc.

FEDERACION DE SALUD DE CALIFORNIA



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CLINICS AND INDIGENT HEALTH CARE

FRED DIAZ, EXECUTIVE DIRECTOR
CALIFORNIA HEALTH FEDERATION, INC.

Senate Symposium on Uncompensated Health Care and Access for the Un-sponsored and Indigent Patient

June 19 and 20, 1986
Sacramento, California

There are 457 licensed Community and Free Clinics (Clinics) in California. Each year they provide about \$250 million of primary care medical services to approximately 1.5 million people. The bulk of these patients are from low income families.

This paper will emphasize three themes concerning the role of Clinics in providing indigent health care. These themes are:

1. Clinics are a significant provider of medical services to low income families. In some areas of the state and for some services, such as obstetrics, they are the only provider of indigent health care services;

2. Clinics are facing financial stresses that threaten their long term financial viability. Loss of Clinics will reduce services available to the poor; additionally Clinics' financial failures will increase the cost of providing indigent care, particularly to local government; and

3. Clinics are efficient medical care providers and have unique cultural, professional and administrative strengths in providing care to the poor. Clinics should be encouraged and nurtured and should be part of any indigent health care program.

CLINIC SERVICES

Clinics are a richly varied lot. They range in size from the very small to multi-million dollar multi-site providers. The smallest consists of a single nurse practitioner working with one or two support employees with an annual budget of about \$150,000. These are usually located in remote areas of the state such as in Butte Valley-Tulelake, Mad River or Potter Valley.

The largest provide multi-specialist medical, mental health, dental, and social services with annual budgets over \$5 million. These tend to be located in urban areas such as in San Francisco's Chinatown, downtown Oakland, and East Los Angeles. Generalizations, however, are risky. For example one of the largest Clinic organizations is located in the grape and cotton fields south Fresno.

All California Clinics are organized as non-profit, public benefit, corporations and all hold Federal and state tax charitable tax exemptions. Their principal charitable purpose is to provide indigent medical and social services. Licensing standards require that all Clinic fees be based on the patient's ability to pay. Additionally, Clinics are prohibited from denying services to anyone because of inability to pay.

The number of Clinic patient visits is steadily increasing. Over the last four years, Clinic patient visits have increased by 25%. The following table shows the number of Clinic visits per year for the past four years.

CLINIC ANNUAL PATIENT VISITS

Year	Number of Visits
1981	4.23 Million
1982	5.19 Million
1983	5.23 Million
1984	5.36 Million

There is no precise way to determine what percentage of these patients are from low income families. A rough guess, though, is that over 75% are medically indigent. One indication that the percentage of poor patients is high is that only 4% of Clinic revenue comes from private health insurance policies.

CLINIC FINANCING

Clinic financial resources--although never strong--have not kept pace with this 25% increase in services. Today, Clinics are stretched to their financial limits, if not beyond. The following table is a rough estimate of Clinic costs and revenue. (It is rough in that the costs only include "operating costs" and therefore do not include necessary non-operating costs such as capital improvements.)

CLINIC COSTS AND REVENUES

Year	Operating Costs	Total Revenue	Difference
1981	\$162,626,428	\$158,244,715	\$4,381,713
1982	194,250,997	203,426,106	<9,175,109>
1983	219,618,928	215,961,108	3,657,820
1984	248,735,233	225,635,225	<23,099,978>

The following table shows the source of revenue by percentage of total revenue:

SOURCES OF CLINIC REVENUE 1984

Source	Percentage of Total Revenue
Patient Revenue	
Private Payments	16.5%
Medi-Cal	10.9
Medicare	3.1
Private Insurance	4.0
Sub-Total	34.5
Grants & Contracts	
Federal	21.6
State	13.0
County/Local	12.2
Private Found.	4.1
Sub-Total	50.9
Other	<u>14.6</u>
TOTAL	100.0%

Grants and Contracts--which make up over 50% of the total revenue--are predominantly Federal and state public health grants. These grants routinely include direct Federal grants such as Community and Migrant Health Center grants; Federal grant funds that are administered by the state such as Special Supplemental Food Program for Women, Infant and Children (WIC); and grants that are totally or partially state funded such as Maternal and Child Health, Family Planning, and Rural and Farmworker Health Development programs.

Clinics finance their operations by essentially stringing together a number of these categorical grant programs. Clinics attempt to take these fragmented public health programs, along with patient fees and Medi-Cal payments, and merge them into a health care program that makes some sort of medical sense.

Clinics face the same operating costs as any other provider. These costs have obviously increased over the last few years at a rate faster than the increase in income. Clinics additionally face costs not normally incurred by other private providers. These unusual costs include the following:

1. The bulk of clinic patients are the poor. These patients often require additional services not normally incurred in treating middle class patients;
2. The cost of administering state and federal grants is high. There is little coordination between the granting agencies. Therefore, record keeping, reporting, service requirements, and accounting requirements are different for each grant; and
3. Clinics are facing extremely high malpractice insurance costs. It is, unfortunately, not unusual for malpractice insurance costs to be 10-15% of the total operating costs.

It is the failure of these public health grant programs and Medi-Cal payments to keep pace with the increase in patient visits and costs that are the principal cause of these financial stresses.

To survive in the long run, Clinics must be financially viable, which means generating sufficient revenue to meet operating costs (including the need to pay competitive salaries) and to replace and improve capital

equipment and structures. It is difficult to determine the number of Clinics with immediate financial difficulties. A number of Clinics, however, are currently having problems keeping accounts payable and payroll current.

If Clinics become bankrupt or are forced to reduce services, these patients are going to become a financial burden on local government. This problem may arise shortly. For example, some Clinics are having trouble finding affordable malpractice insurance to cover obstetric services. If they stop these services due to the lack of insurance, these patients will likely end up at county hospitals and clinics.

Indigent health care programs cannot merely look at the "unsponsored" poor patient but must look at the total financial strength of the institution. For example, a Medi-Cal payment rate that pays only one-half of the cost of a visit is as detrimental as having "unsponsored" patients.

CLINIC STRENGTHS

Clinics are unique health care providers in that their principal activity is providing health and social services to low income families. Indigent health care is not side line or merely another name for bad debts. Although many Clinics are attempting to broaden their patient base because of the need to generate higher revenue, it is likely that Clinics will continue for the foreseeable future to be principally low income patient providers.

Clinics, in general, are efficient providers. Their average cost per visit in 1984 was \$45.00 which compares favorably with private physicians, hospital out-patient facilities, and county programs. Additionally, there is evidence that Clinics make less use of surgical and hospital services for their patients than other providers.

Clinics often have unique abilities to work with low income families and provide indigent health care services:

1. Clinic staffs usually have cultural roots reflective of their patients and attempts are made to offer necessary ancillary services such as nutrition, family planning and other counselling and translation services. This should lead to better health care;

2. Clinics have the flexibility, excitement, and innovative abilities inherent in being a private non-profit organization;

3. Clinics' professional staffs operate within an organized structure, with team approaches to treatment and established utilization and quality control systems, that help improve the quality of care; and

4. Clinics usually have the sophisticated management and accounting systems necessary to run complex health care programs and major experience running government grant programs.

These are resources that the community should take advantage of in planning all medically indigent care programs.

White Paper on The Evolution of H.E.L.P:
Addressing Uncompensated Care in Contra Costa County
The Work of the Public-Private Partnership Task Force
of the Contra Costa Health Coalition

Prepared For
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and
Access for the Uninsured
and Indigent Patient

Presented By
Senate Coalition on Health Care
Nancy Burt, Chairperson

Sponsored By
Senate Rules Committee
Senator David Roberti, Chair
Senator William A. Craven, Vice-Chair

June 1986

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The Evolution of H.E.L.P
Addressing Uncompensated Care in Contra Costa County

The Work of the Public-Private Partnership Task Force
of the Contra Costa Health Coalition

I. Activities to Date

The Public-Private Partnership Task Force of the Contra Costa Health Coalition has been working for the past 2 1/2 years to develop a fair and workable approach to dealing with the issue of uncompensated care in Contra Costa County.

The issue of uncompensated care can be summarized by the following facts:

Some Contra Costans do not have/cannot get health insurance.

Private hospitals in Contra Costa have traditionally provided a major share of the care received by the uninsured.

This care has been funded by charge-shifting to private insurance companies and to the companies and individuals who paid premiums to the private insurance companies.

Changes in the payment system are eliminating the ability of private hospitals to fund "uncompensated" care through traditional charge-shifting.

If private hospitals cannot generate an alternative source of funds, they will be unable to continue to provide care to the uninsured.

The County cannot absorb the uninsured population that is now being served by the private hospitals.

Given these facts, the Task Force identified a series of options:

Accept the denial of care needed by the uninsured.

Require and provide universal health insurance coverage.

Develop a new system for funding "uncompensated" care.

The Evolution of H.E.L.P

The Task Force then decided that:

Denial of care is morally unacceptable.

Universal health insurance is not politically feasible.

A new funding system is required.

The Task Force examined a number of potential sources of funds, including government (general revenue funds) and taxes on hospitals. However, government was eliminated as a potential near-term funding source, because:

Federal and State governments have run into the Gramm/Rudman and Gann spending limits, respectively, and

County funding - either for expansion of the county health system to allow the county to absorb the uninsured population now seen in the private sector, or to subsidize the care provided by the private sector - is unavailable due to restrictions on the County's ability to raise tax revenues.

A tax on hospitals was also eliminated, because with hospitals losing the ability to shift charges, hospitals do not have the resources to fund uncompensated care.

Therefore, the Task Force decided that the source of funds would have to:

be collected locally by a non-governmental agency, and

be obtained from as broad a population as possible, so that the responsibility for funding uncompensated care would be shared as equitably as possible.

The mechanism for assessing payors and for distributing the funds to providers of uncompensated care would have to be as simple as possible without encouraging inappropriate behavior by payors, providers, or patients. The funding system would also have to avoid discriminating among hospitals or insurers in order to be compatible with competition and to preserve the gains in efficiency that have developed from competition.

The broadest segment of the population that can be charged by a non-governmental agency is the population with health insurance. This is the population that has traditionally paid for uncompensated care - through charge shifting. However, a large

part of the insured population - those insured by government programs (Medicare and Medi-Cal), HMOs and PPOs with negotiated discounts, and Kaiser (which does not serve the uninsured population) - no longer share in paying for uncompensated care.

The Task Force determined that the simplest and fairest way to get these insurers to share in the cost of uncompensated care would be to develop a shared-risk pool and base contributions on the proportion of their utilization of hospital services. The simplest measure of utilization is the number of days their members spend in the hospital. Thus, the Task Force decided to fund the uncompensated care program by collecting a flat fee surcharge from each insurer for each day that one of their members is in a Contra Costa hospital. Self-insured patients would be exempt from the surcharge.

Hospitals in Contra Costa provide about \$12 million in care each year to people who cannot or do not pay their bills. The Task Force has proposed that the risk share pool be funded at \$3 million per year -- not enough to solve the problem of uncompensated care, but enough to buy time until a more permanent solution can be developed. This would require that the insurers pay a surcharge of about \$8 per day.

This surcharge would be collected by each hospital and transferred to the non-profit corporation or joint powers agency that administers the shared-risk pool. This agency would be responsible for developing patient eligibility criteria and utilization monitoring/control systems, as well as paying hospitals and physicians for the uncompensated care they provide.

All hospitals would be eligible for payment from the shared-risk pool, although the County hospital would probably have a cap on the total amount it could receive from the pool. Hospitals would probably be paid a flat per diem that is below the Medi-Cal rate. The Task Force is still exploring methods for compensating physicians for inpatient services.

II. Next Steps

The shared-risk pool would be a partial solution to a serious and growing problem. Implementation of the risk pool would buy time until a more permanent solution can be developed. However, there is much work to be done -- to educate the industry and the public, refine the concept, and develop appropriate model legislation -- before a risk pool, or similar program, can be implemented.

The Task Force is putting together an educational strategy involving:

- o A White Paper series to be prepared by the ACCHSA, including studies on:

- Charge-Shifting
- Extent of the Uninsured Population in Contra Costa County
- Health of County Health Services in the East Bay
- Review of Other Relevant Local- and State-Level Experiments in Uncompensated Care Financing/Delivery Systems
- Case Studies

- o Informational/Outreach Materials directed toward major interest groups (e.g., employers, labor, senior citizens, hospitals, physicians, insurers, etc.), including

- Brochures
- Briefing Packets
- Slide Presentations

- o A Speakers Bureau
- o Community Assemblies/Public Forums (1 or 2)
- o A Hospital Based Study of Bad Debt and Charity Care

The ACCHSA has been providing technical assistance to the Public Private Task Force for the past 2 1/2 years. This educational strategy will require that the ACCHSA take on additional responsibilities and commit additional resources to this project for the next 6 to 12 months. This strategy will also require the committment of additional time and resources by the County and local hospitals, and it may require the establishment of a third-stage Public-Private Task Force to revise and refine the proposal for the establishment of a local shared risk pool. The work of the Public-Private Task Force and the Contra Costa Health Coalition is now at a critical point.

HEALTH PLANNING CENTER

EXECUTIVE SUMMARY

UNCOMPENSATED CARE AND THE UNINSURED IN SAN DIEGO AND IMPERIAL COUNTY ACUTE CARE HOSPITALS 6/17/86

The national crisis in hospital care for the uninsured is especially acute in the San Diego/Imperial County Health Service Area due to the recent loss of local Indigent Care Agreements (worth about \$2 million over the last five years). These Agreements, negotiated as conditions to the Certificate of Need process, required certain hospitals to provide a "fair share" of indigent care. Today, Certificate of Need is no longer a factor, the Agreements are expiring, and competitive forces are further eroding previous sources of indigent care. Also, after 1986, only 3 of the original 14 Hill-Burton Charity Care obligations will remain in effect.

This research documents the effects of recent changes in hospital financing and reimbursement on the level and scope of uncompensated care in acute care facilities, providing a baseline from which ongoing trend data can be derived. The study compiles and analyzes data for Health Service Area 14, San Diego and Imperial Counties, and compares the findings with State of California data. It also contrasts a poor county (Imperial) with a large minority population to a large, affluent, conservative urban area (San Diego County). Discharge data were taken from the Discharge Data Summary, 1983, and financial data were extracted from three years of Individual Hospital Financial Data (Cycles 7-9, FY 1980-83), compiled by the California Health Facilities Commission. Effects on UCSD Medical Center, county government, and the uninsured are highlighted.

Uncompensated care (UC) levels remained relatively stable for the three years studied, while the number of uninsured grew by over 20%. Financial data (adjusted for charge-to-cost variations) for San Diego County reveal that non-profit hospitals averaged UC rates of 2.3%, while for-profit and district hospitals held their average rates to 1.8% of GPR. Imperial County reported a much higher UC level, 4.4% of GPR. Individual hospital UC rates ranged from 0.65% to 8.78% of GPR. In the 8th cycle (FY ending 6/30/81 to 6/29/82) the 30 hospitals studied reported over \$26 million, or 2.6% of GPR, in uncompensated care costs.

In contrast to state trends, charity care in HSA 14 showed an increase that coincided with the peak period of the Indigent Care Agreements (0.41% to 0.57% of GPR). The designated gatekeeper, the Council of Community Clinics, has relied heavily on these agreements for vital inpatient services for uninsured patients. Participating physicians and patients report high satisfaction with this efficient and effective method of providing charity care. At present there is no source available to fill the gap left after these agreements expire.

San Diego County lacks a public hospital, therefore the question remains, does the private sector meet any portion of the needs of those who are served by public hospitals elsewhere? The data do not indicate any increased provision of care to the uninsured by profit, non-profit, or district hospitals. Uncompensated care levels for these management categories in San Diego County are remarkably similar to statewide rates.

UCSD Medical Center, however, does show higher uncompensated care rates than voluntary teaching hospitals statewide, over 2% higher during the 8th cycle. These figures also underestimate due to recently-adopted screening procedures that reduced the Medical Center's UC rates. Thus, while other programs for the uninsured poor are shutting down, UCSD Medical Center has been absorbing some of those patients, and obtaining more reimbursement for their care.

The estimated 35 million Americans who lack any form of public or private insurance, when they seek care, are listed and billed as "Self-Pay" patients. (Unknown numbers of wealthy patients paying full charges, including many non-resident Hispanics, are also coded as Self-Pay.) This category, combined with "No Charge", or charity patients, is analyzed to approximate information on the uninsured. Given the limits of this source, data for 1983 show that in San Diego County Hispanics are disproportionately represented among Self-Pay and No Charge (SP & NC) patients: 34.5% are Hispanic as compared to 12.4% of all other discharges. Blacks and Asians are underrepresented with rates of 2.3% and 0.2% in the SP & NC category, as compared to 5.5% and 2.4% of all other discharges.

These findings reflect the presence of a large undocumented population ineligible for government programs, but may also indicate that medically indigent Blacks and Asians are better able to access the health care system and enroll in public programs than are medically indigent Hispanics. Expansion of special educational programs directed toward enrolling a larger number of legal Hispanic residents in government programs will reduce uncompensated care costs.

Information on type of admission, disposition, sex, and age is also presented for Self-Pay and No Charge patients. The subset of Self-Pay and No Charge patients who enter the hospital as Urgent or Emergency admissions is also analyzed.

Recommendations for further study include expanding future uncompensated care reports to analyze other indigent payor sources, and tracking the effects of competition on indigents over longer time periods and in more detail. Recommendations for local action include involving government and private sector healthcare leaders in collective efforts to address the uncompensated care issue, developing expanded prenatal care programs, and establishing local insurance and free care programs to reach more uninsured.



Report to the Board of Directors

Date Mailed to Board May 2, 1986

Date of Board Meeting May 16, 1986

Report of Health Care Policy Committee

Subject Medical Care for the Uninsured

<input checked="" type="checkbox"/>	Board Action Recommended
<input type="checkbox"/>	Consent Calendar
<input type="checkbox"/>	Information Only

Status

Numerous bills are surfacing in the Legislature to address the problem of financing uncompensated medical care. "Uncompensated care" is used to define medical services rendered to persons who are uninsured or underinsured, or who do not have financial resources available to pay for those services.

Action Recommended

- 1 That the California Chamber of Commerce SUPPORT requesting the Governor to
- 2 appoint a broad-based commission to look at how best to address the
- 3 uncompensated medical care problem and to make recommendations back
- 4 to the Governor. Further, that the commission be directed to explore the
- 5 areas outlined in Attachment A.

Background

It is estimated that in California over 10 percent of the population is without any health insurance throughout the year, and another 9 percent is without health insurance for some part of the year. The problem of how to finance necessary medical care for this population has been exacerbated by the contracting and competition that is taking place both in Medi-Cal and the private insurance sector. The Legislature is seeking ways to either (1) establish a source of stable funding for this population's medical care; or (2) find a way to provide private insurance coverage for this group at affordable rates.

Recognizing the growing interest on the part of the Legislature to try to address this problem and the need for business to review this issue as it impacts employers, the Health Care Policy Committee appointed a task force last year to study the problems of (1) uncompensated care for hospitals and other providers and (2) the unavailability of affordable health insurance for many Californians. That task force met six times and heard from representatives of various organizations involved with this issue, including the provider community, organizations representing the poor, and representatives of the Legislature and the Administration. The task force was impressed with the quality, and overwhelmed by the quantity, of research that has been done in this area of existing programs to special user taxes, to state insurance pools to provide coverage for this group. After listening to all the concerns and recommendations of the guest speakers, and reviewing the literature available, the task force reached the following conclusions:

1. California business is currently paying a share of the uninsured and underinsured burden through cost-shifts by providers to their insured patients. Business will also be picking up additional costs in group health plans due to adverse risk

Medical Care for the Uninsured

ATTACHMENT A

1. Define the scope of the problem and the current available resources. There are numerous state and federal programs already in place for different segments of this population. The commission should determine what needs are currently being met and what needs remain to be addressed. Attention can then be focused on how to better coordinate existing programs and what new programs are necessary to fill in the gaps.
2. Explore the feasibility of expanding the Medi-Cal program to allow persons to buy into the program. A graduated premium scale could be instituted to generate additional monies to offset some of the cost. This would enable the state to use existing contract providers and administrative channels, and would eliminate the need for a separate program.
3. Special consideration should be given to targeting solutions to identified high cost groups; i.e., prenatal and maternity care; illegal aliens; displaced homemakers; terminally ill patients.
4. Input should be solicited from the many groups that are currently working independently on this issue to avoid duplication of effort.

The California Chamber of Commerce is committed to working with the Governor and the commission in developing a sound and viable solution to the issue of uncompensated care.

